MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83 09492

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Rural - Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo.
Hospital, institution, or street address where death occurred: Quarters "A" Naval Med. Center
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Mont.
City or town Rural - Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. Quarters "A" Naval Med. Center
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CARRIE KEMP ACKERMAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Abram J. Ackerman
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Apr. 5 1865

8. AGE: Years 83 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Yonkers, N.Y. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER — 12. Name: John A. Kemp.
13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Cordelia Manchester
15. Birthplace: N.Y.

16. Informant: Urban Jay Ackerman
Address: Cornwall Bridge Conn.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3 1948 (month) (day) (year)
Cemetery or crematory: Forest Hill
Location: Memphis, Tenn.

18. Funeral director: Joseph Gawler's Sons
Address 1756 - Pa. Ave. N.W.

19. 9/30 1948 W.E. Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1948 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 1946 to September 30 1948 and that I last saw her alive on September 30 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	36 hrs.
Due to Arteriosclerosis	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: John L. Cooley LCdr MC USN
Address: Naval Medical Center Date signed 9/30/48
M.D. or other

VS A15 9-45.1

(1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

09493

CERTIFICATE OF DEATH

Reg. Dist. No. 2/8

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg D, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Mont.
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: EMMa Girtrude Andrews

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 17th 1867

8. AGE: Years	Months	Days	If less than one day
81	0	19	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: House Keeping
11. Industry or business

FATHER
12. Name: James W Andrews
13. Birthplace: Md,

MOTHER
14. Maiden name: Letha A Reed,
15. Birthplace: Md

16. Informant: 111 West Glen Brook Rd,
Address: Bethesda, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/9/48 (month) (day) (year)
Cemetery or crematory: Neelsville Cemetery
Location: Germantown D
18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Sept. 8 1948 Alfreda G. Locke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept - 6 - 1948 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 5 - 1947 to Sept. 6 - 1948 and that I last saw h.. alive on Sept. 6 - 1948.

Immediate cause of death	DURATION
acute heart failure	11 hours
Due to: senility	
Arterio - sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Julian E. Miller, M.D.
M. D. or other
Address: Gaithersburg, Md. Date signed 9/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09494

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122b

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 4 hours 40 min.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 day 4 hours 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: ?

City or town: Falls Church Va.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 112 Lawrence Drive

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MAXINE ANGLIN MRS.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Randolph Sterling Anglin

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): may 6 1924.

8. AGE: Years	Months	Days	If less than one day
24	4	15	hrs. min.

9. Birthplace: Buckhannan, West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Russell Riggs

13. Birthplace: West Virginia

MOTHER

14. Maiden name: Myrtle Tenney

15. Birthplace: West Virginia

16. Informant: Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24-1948 (month) (day) (year)

Cemetery or crematory: BAPTIST CEMETERY

Location: BUCKHANNON, WEST VA.

18. Funeral director: FITZGERALD FUNERAL HOME

Address: ARLINGTON, VA.

19. Sept 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1948, at 2 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1948, to Sept 21 1948

and that I last saw her alive on Sept 21 1948

Immediate cause of death: Volvulus with secondary gangrene

DURATION: 24 hrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Volvulus

Date of op. Sept 21

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M D

M. D. or other

Address: Silver Spring Md Date signed: 9-21-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete. MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Evidence for change in date of birth shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09495

FILM No. G 1170CT 5 1948 **CERTIFICATE OF DEATH**

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
708 Bonifant Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 708 Bonifant St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME

MARY GERMAINE AUSTIN

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Edwin Lynwood Austin

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.) ~~May 24, 1894~~ March 18, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	6	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Clerk, U. S. Post Office Dept.

11. Industry or business

FATHER
12. Name: William Thomas Stormont
13. Birthplace: New York

MOTHER
14. Maiden name: Mary Ellen Wade
15. Birthplace: Washington, D. C.

16. Informant: Edwin L. Austin
Address: 708 Bonifant St., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington, D. C.

18. Funeral director: Waxnax E. Pumphrey, Inc.

Address: 8434 Ga. Ave., Silver Spring, Md.

19. Sept 75 1948 Josephine M. Scheffler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 1948 at 5:47 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1948 to Sept 24 1948 and that I last saw h[illegible] alive on Sept 24 1948

Immediate cause of death	DURATION
Carcinoma of Liver	5 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Louis A. Comstock M. D. or other

Address: 1927 Wirth Ct. S.E. Date signed: 9/24/48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09496

157e

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 25 days

Hospital, institution, or street address where death occurred:

9308 Longbranch Parkway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9308 Longbranch Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

FRANCES BARBEE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1, 1948

8. AGE:

Years	Months	Days	If less than one day
0	2	25	..... hrs. ..... min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: John William Barbee

13. Birthplace: Silver Spring Md.

MOTHER

14. Maiden name: Nellie Gleary

15. Birthplace: Penn

18. Informant: John William Barbee

Address: 9308 Longbranch Pky. S.S. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 29, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington, D. C.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: 8434 Ga. Ave., Silver Spring, Md.

19. Sept 27 1948 Josephine M. Schaeffle

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 1948 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 26 1948

and that I last saw her alive on Aug 1, 1948 1948

Immediate cause of death	DURATION
Congenital Heart Disease	from birth.
Due to	
Due to	

Other conditions: Other Congenital abnormalities including ears, one eye and probably brain

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard V. Mattingly M.D.

M. D. or other

Address: 4707 Conn. Ave. NW. Wash. DC. Date signed: 9/26/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09497

50

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 18 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Compass Green, S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME BIGBIE, Lois,(n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: XX Amzie L. Bigbie

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1911

8. AGE: Years	Months	Days	If less than one day
37	5	4	..... hrs. ..... min.

9. Birthplace: Ark.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: James Thomas Mendenhall
13. Birthplace: Arkansas

MOTHER
14. Maiden name: Mary Tarbrough
15. Birthplace: Arkansas

16. Informant: husband: Amzie L. Bigbie

Address: 13 Compass Green, S.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-48 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

16. Funeral director: W.W. Chambers F.E.T.

Address: 517 11th St S.E. Washington, D.C.

19. 9-4-48 (Date rec'd by registrar) x Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 September 19 48 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 July 19 48 to 3 September 19 48 and that I last saw her alive on 3 September 19 48

Immediate cause of death	DURATION
Bronchopneumonia,	4 days.
Due to: Pulmonary metastases	
Due to: Adenocarcinoma of breast	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Kirkpatrick Jr. H. KIRKPATRICK, Jr. Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 9-4-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

09498

Reg. Dist. No. V 14

1. PLACE OF DEATH:

County PRINCE GEORGES

City or town R.F.D. #2, SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 DAYS

Hospital, Institution, or street address where death occurred: MRS. JOLLIFFES NURSING HOME

How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WASHINGTON County D.C.

City or town —

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1410 MANCHESTER LANE, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war NONE ✓

3. (a) FULL NAME Harvey H Brayton

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife MARGARET J. BRAYTON

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) 4/14/1870

8. AGE: Years 78 | Months 6 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace JANESVILLE, WISC. (Town, county, and state)

10. Usual occupation LINOTYPE OPR.

11. Industry or business G.P.O.

FATHER 12. Name WM. E. BRAYTON

13. Birthplace —

MOTHER 14. Maiden name —

15. Birthplace —

16. Informant MRS. JOLLIFFES NURSING HOME

Address R.F.D. #2 SILVER SPRING, MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct 1, 1948 (month) (day) (year)

Cemetery or crematory FOREST LAWN

Location BLADENSBURG MD.

18. Funeral director LEE'S FUNERAL HOME

Address 300 - 4 ST N.E. D.C.

19. Oct 29 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948 at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-24 1948 to 9-28 1948

and that I last saw h[illegible] alive on 9-27 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	15 min.
Due to Cerebral Arteriosclerosis	1 yr.
Due to Senile lack of Clarity of Mind	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? — NO

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 9-[illegible]-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

Evidence for change of age shown on:

FILM No. G 17 SEP 22 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51 0949

Reg. Dist. No. 514

1. PLACE OF DEATH:
County: Montgomery
City or town: Forest Glen, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, Institution, or street address where death occurred: 8 Capital View Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Forest Glen (If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 Capital View Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American and WW I

3.(a) FULL NAME: Charles Kelly Brewer, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude M. Brewer
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): December 30 1880

8. AGE: Years	Months	Days	If less than one day
67/8/	8	5	...hrs. ...min.

9. Birthplace: Waycross, Georgia (Town, county, and state)
10. Usual occupation: Retired M/Sgt US Army
11. Industry or business

FATHER
12. Name: Charles K. Brewer
13. Birthplace: Waycross, Georgia

MOTHER
14. Maiden name: Not known
15. Birthplace: " "

16. Informant: Charles F. Brewer Son
Address: 8 Capital View Ave., Forest Glen, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1948 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Fort Myer, Va.

18. Funeral director: Waxner E. Pumphrey, Inc.
Address: Silver Spring, Md.

19. Sept 5 1948 (Date received by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 September 1948 at 10.00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to 4 Sept 1948 and that I last saw him alive on 4 September 1948

Immediate cause of death: Adenocarcinoma of prostate with cerebral metastis. — DURATION: 3 yrs

Due to: Cause unknown

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. B. Moffett, 1st Lt. M.C.
M. D. or other
Address: ARMY MEDICAL CENTER WASHINGTON, D. C. Date signed: Sept. 4 '48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e

09560

Reg. Dist. No. 7/16

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5231 Wisconsin Ave. NW.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Robert J. Broege

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anne
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1885.

8. AGE:

Years	Months	Days	If less than one day
63	3	12	hrs. min.

9. Birthplace: Jamesville, Wisc. (Town, county, and state)
10. Usual occupation: Marine Engineer
11. Industry or business: U.S. Navy dept.
FATHER 12. Name: Frederick Broege
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Marie Hein
MOTHER 15. Birthplace: Germany
16. Informant: wife
Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-14-48 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Blue Island, Ill.
18. Funeral director: Chevy Chase Funeral Home
Address: 5103 Wisconsin Ave. N.W. D.C.
19. 9/11 1948 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1948, at 10 15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Nov 1947 to 11 Sept 1948 and that I last saw h[illegible] alive on 10 Sept 1948

Immediate cause of death	DURATION
Peritonitis	
Due to: Perforation of ca of colon	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of the Splenic Flexure Date of op. 2 Sept 48
Autopsy results: Peritonitis - Perforation ca
PHYSICIAN: Please underline the cause to which death should be charged statistically. Jeb.

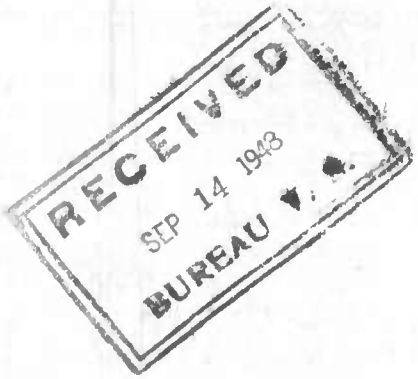
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward L. Wilson M.D.
M. D. or other
Address: 1801 - E 38th NW Date signed: 11 Sept 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15


RECEIVED
SEP 14 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09501

CERTIFICATE OF DEATH

Reg. Dist. No. 7-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:

8600 Old Georgetown Rd: Suburban Hospital

How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural — Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6018 River Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Hattie X Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married (separated)

6.(b) Name of husband ~~or wife~~: Bishop Brown

6.(c) If alive, give age: X years

7. Birth date of deceased (mo., day, yr.): July 22, 1903

8. AGE: Years	Months	Days	If less than one day
45	2	18	4 hrs. 43 min.

9. Birthplace: Mt. Carmel, South Carolina (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER — 12. Name: Allan Banks

13. Birthplace: Mt. Carmel, South Carolina

MOTHER — 14. Maiden name: Rachel X

15. Birthplace: Mt. Carmel, South Carolina

16. Informant: Frank Brown (Son)

Address: 5 Carver Rd; Cabin John, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14, 1948 (month) (day) (year)

Cemetery or crematory: [illegible]

Location: Lincoln Memorial Cem.

18. Funeral director: Mc Gunn Funeral Home

Address: 870 - 9 St. N.W.

19. 9/10 19 48 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept - 10, 1948, at 4 40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 8 1948 to SEPT. 10 1948 and that I last saw h ER alive on SEPT 10 1948

Immediate cause of death	DURATION
PULMONARY INFARCTION	4 DAYS
Due to EMBOLUS	4-5 DAYS
Due to MYOCARDIAL INFARCTION 1 MO OR MORE	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE

Date of op.

Autopsy results: BILATERAL PULMONARY INFARCTION MYOCARDIAL INFARCTION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ira W. Pearlman M.D

M. D. or other

Address: Suburban Hospital Bethesda 14, Md. Date signed 9-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09502

CERTIFICATE OF DEATH

Reg. Dist. No. Y 14

1. PLACE OF DEATH:

County: Montgomery

City or town: Garrett Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

15 Pembroke St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Garrett Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 15 Pembroke St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Jeanne Winchester Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M.

6.(b) Name of husband or wife: Walter Nicholas Brown 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 13, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	15	hrs. min.

9. Birthplace: Annandale, Va.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Elhanan W. Wakefield

13. Birthplace: Ohio

MOTHER

14. Maiden name: Mary R. Tennyson

15. Birthplace: Annandale, Va.

16. Informant: Mr. Walter N. Brown

Address: 15 Pembroke St. Garrett Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 2, 1948 (month) (day) (year)

Cemetery or crematory: Centry Co. Mem. Park

Location: State College, Pa.

18. Funeral director: Warren E. Pumphrey, Inc.

Address: 8434 Georgia Ave., Silver Spring, Md.

19. Sept 29 1948 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Sept 1948 at 6:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-3 1948 to 9-28 1948

and that I last saw h.. alive on 9-26 1948

Immediate cause of death	DURATION
Myocardial Infarction	6 mo.
Coronary Thrombosis	
Due to: Ca of st. Breast	12 yrs
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Covey M.D. M. D. or other

Address: 1750 Eye St. N.W. Washington, D.C. Date signed: 9-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

125b

09503

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Arlington,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1431 South 28th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BRUNER, Velva Corine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W -US	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-11-48

8. AGE:

Years	Months	Days	If less than one day
0	0	3	hrs. min.

9. Birthplace: Bethesda, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Lawrence Leroy Bruner
13. Birthplace: Wyo.

MOTHER
14. Maiden name: Eddie Mae Winters
15. Birthplace: Missouri

16. Informant: Father Mr. Lawrence Leroy Bruner
Address: 1431 South 28th St. Arlington, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-16-48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers
Address: 3072 M. St. Georgetown, D. C.

19. 9-15 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 September 1948, at 02:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 September 1948, to 14 Sept. 1948 and that I last saw h er alive on 9-14-48 1948

	DURATION
Immediate cause of death: massive hemoperitoneum	1 hr
Due to: Subcapsular hemorrhage of liver with rupture.	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. J. FOWLER JR. CDR MC USN
M. D. or other
Address: USNH, Bethesda, Md. Date signed 9-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09504

51C

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 19 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 7 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County:

City or town: Columbus
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2733 Baughman Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3. (a) FULL NAME: BUTLER, Richard Dale

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Evalyn M. Butler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 6, 1925

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
22	11	1		

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: BUTLER, Matthew
13. Birthplace: Ohio

MOTHER
14. Maiden name: TOLLIVER, Ella Lou
15. Birthplace: Ohio

16. Informant: wife: Mrs. Evalyn M. Butler
Address: 2733 Baughman St., Columbus, Ohio

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9-11-48 (month) (day) (year)

Cemetery or crematory:

Location: Columbus, Ohio

19. Funeral director: W. W. CHAMBERS O.M.K.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 9-7- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 September 19 48 at 5:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 January 19 48 to 7 September 19 48 and that I last saw him alive on 7 September 19 48

	DURATION
Immediate cause of death: GENERALIZED CARCINOMATOSIS	4 mo.
Due to: CARCINOMA LEFT TESTICLE	6 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: CA OF TESTICLE Date of op. May 1948

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

R. N. WEBSTER, Lt. JG MC USN

23. SIGNATURE: M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-7-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09505

94a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:
8529 Locust Hill Road

How long in hospital or institution? Died at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8529 Locust Hill Road
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Helene M. Carlson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Carl Emil Carlson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 2, 1872

8. AGE: Years	Months	Days	If less than one day
76 . 76	4	27	..... hrs. ..... min.

9. Birthplace Norway
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER

12. Name George Gulbransen

13. Birthplace Norway

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Charles Carlson (son)

Address 2445 15th St. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/48 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D.C.

18. Funeral director Wm. Reuben Pumphrey

Address 7557 Wisconsin Avenue

19. 9/30 (Date rec'd by registrar) 19 48 W.E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 19 48, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 19 to 19 and that I last saw h... alive on ... 19

Immediate cause of death Coronary occlusion — DURATION: about 2 days

Due to ... DURATION: suddenly

Due to ...

Other conditions ...

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Asst. Med. Exam. M. D. or other

Address Frederick Md. Date signed 9-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH BIRTH + DEATH 09506

CERTIFICATE OF ~~STILLBIRTH~~ 160C

Reg. Dist. No. 217

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Montgomery
   City or town Olney
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: The Montgomery County General Hospital Inc.
   Length of mother's stay in County
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County Montgomery
   City or town Clarksburg
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. Box 58
   (If RURAL give LOCATION)

3. Name of child Carroll
4. Date of birth Sept. 8 1948 Hour 2:15 P.M.
5. Sex Female | 6. Twin or triplet —
7. No. of weeks pregnancy 26 weeks.

FATHER OF CHILD

8. Full name Charles Wesley Moore
9. Color Col. 10. Age at time of this birth 26 yrs.
11. Usual occupation laborer

MOTHER OF CHILD

12. Full maiden name Ruth Rebecca Carroll
13. Color Col. 14. Age at time of this birth 22 yrs.
15. Usual occupation Housework.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of Premature Separation of placenta
19. Labor: (a) Complications of None
(b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
(b) State all operations, if any —
(c) Did child die before operation? —
During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes Prematurity
(b) Maternal causes Premature separation of placenta

22. I certify to the birth of this child who was born dead* on the date and hour above stated. (C. Lee Randal)
Signature Clee Randol MD
(Specify if M. D., midwife, or other)
Address Damascus Md

23. (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 9 1948 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill Md
24. (a) Funeral director Roy W Barker
(b) Address Gaithersville Md

25. (a) Sept 8 48 (Date rec'd by registrar) (b) Gertrude B Lawler (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

* See Instruction C on stub.

V. S. A10

Baby breathed 1 hour + 25 minutes.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09507

74a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 9-4-'48 11 A.M.

Hospital, institution, or street address where death occurred: Suburban Hosp.
8600 Old Georgetown Rd. - Bethesda Md.,

How long in hospital or institution: Since 9-4-'48

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore Rd.,
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs Violet Carter

3. (b) Social Security Number: No. Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh.	

6.(b) Name of husband or wife: George F.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1910

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
38	5	28		

9. Birthplace: Hagerstown Md.,
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Morris Alexander
13. Birthplace: Hagerstown Md,

MOTHER
14. Maiden name: Bertha E. Zittle
15. Birthplace: Hagerstown Md.

16. Informant: Mr. George F. Carter
Address: B.&O. Station-Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/25/48 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Reuben Pearson

Address: 7557 Wisconsin Avenue Bethesda

19. 9/27 19 48 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22, 1948 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/4 1948 to 9/22 1948.

and that I last saw her alive on 9/21 1948

Immediate cause of death	DURATION
Malignancy Leukemia.	
Due to: —	
Due to: —	
Other conditions: Intra-peritoneal hemorrhage. (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lemuel T. Kimble M.D.
M. D. or other

Address: 1726 Eye St. N.W. Wash. D.C. Date signed: 9/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09508

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, Institution, or street address where death occurred:
3005 Wheaton Road
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3005 Wheaton Road
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: Francis E. CHASE (Francis E. Chase)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie S. Chase
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 23, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	4	hrs. min.

9. Birthplace: Rutland, Ohio (Town, county, and state)
10. Usual occupation: Broker
11. Industry or business: Real Estate

FATHER
12. Name: Henry F. Chase
13. Birthplace: Ohio

MOTHER
14. Maiden name: Addie Stowe
15. Birthplace: Ohio

16. Informant: Mrs. Elsie S. Chase (wife)
Address: Kensington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30, 1948 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: Wm. Reardon Funeral Home
Address: Bethesda, Maryland

19. Sept. 29, 1948 (Date rec'd by registrar) W. E. Gobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/27/48 19 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19 to 9/26 19 48
and that I last saw h.i.m alive on 9/26 19 48

Immediate cause of death	DURATION
a. Cerebral Coronary Thrombosis	1 day
Due to: Cerebral Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.
Autopsy results: X
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: X
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Samuel Allen MD M. D. or other
Address: Kensington, Md. Date signed: 9/27/48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09509

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 9-22-48

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda Md.

How long in hospital or institution? Since 9-22-'48

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5746 Colorada Ave. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward E. Cissel

3.(b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
m	wh.	

6.(b) Name of husband or wife: Alberta Cissel

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	26	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Purchasing agent

11. Industry or business:

FATHER — 12. Name: Ernest E. Cissel

13. Birthplace: Wash

MOTHER — 14. Maiden name: Charlotte E. Brailey

15. Birthplace: N.H.

16. Informant: ALBERTA CISSEL

Address: 5746 COLORADO AVE N.W.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: SEPT 28 48 (month) (day) (year)

Cemetery or crematory: CEDAR HILL

Location: MARYLAND

18. Funeral director: The S.H. Kines Co

Address: 2401 14TH ST N.W. Washington D.C.

19. 9/27 19 48 (Date rec'd by registrar) W.E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-26-48 19 48 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Sept 1948 to 26 Sept 1948 and that I last saw him alive on 25 Sept 1948

Immediate cause of death	DURATION
Hemorrhage Retroperitoneal	2 hours.
Due to: Dissecting aneurysm abdominal aorta	9 days
Due to: arteriosclerosis	5-10 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John S. Fawcett M.D. M. D. or other

Address: P.O. Bayds, Md. Date signed: 26 Sept. 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09510

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

4836 Bradley Blvd.,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4836 Bradley Blvd.,

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: LAWRENCE SNOWDEN COSGRAVE

3. (b) Social Security Number: 578-10-5397

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ada Viola Cosgrave

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6th, 1890

8. AGE: Years	Months	Days	If less than one day
58 58	5	4	..... hrs. ..... min.

9. Birthplace: Montgomery County, Maryland (Town, county, and state)

10. Usual occupation: Operator

11. Industry or business: Capital Transit Company

MOTHER-FATHER

12. Name: William Joseph Cosgrave

13. Birthplace: Ireland

14. Maiden name: Alice Virginia Plumer

15. Birthplace: Frederick County, Maryland

16. Informant: Mr. Ira Nichols (nephew)

Address: Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12, 1948 (month) (day) (year)

Cemetery or crematory: Monocacy Cemetery

Location: Beallsville, Maryland

18. Funeral director: W.M. Speaker Funeral Home

Address: Bethesda, Maryland

19. Sept. 12th 1948 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9th September 19 48, at 4 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 19 48 to Sept. 9 19 48 and that I last saw him alive on Sept. 8 19 48

Immediate cause of death	DURATION
Immediate cause of death: Auto-intoxication + Uremia	
Due to: Bronchogenic Carcinoma	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L. L. Markea, M.D. M. D. or other

Address: 6306 Wisconsin Ave., Bethesda, Maryland Date signed: 9/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b

09517

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.Y. County:

City or town: New York(29)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 51 East 97th St., Apt. 3-A
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: COURTNEY, William Hubert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Helen Courtney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	5	0		

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER
12. Name: COURTNEY, Thomas dec
13. Birthplace: Pa.

MOTHER
14. Maiden name: OHERN, Ella dec
15. Birthplace: N.Y.

16. Informant: Wife: Mrs. Helen Courtney
Address: 51 East 97th St., N.Y., 29, N.Y.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9-21-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers

Address: Georgetown, D.C.

19. 9-18 (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 September 19 48 at 11:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Sept. 19 48 to 18 Sept. 19 48 and that I last saw him alive on 18 September 19 48

Immediate cause of death	DURATION
Pneumonia, Broncho	6 days
Due to: Cirrhosis, liver, atrophic	indef.
Due to: Hemochromatosis	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. E. Watters
L. E. WATTERS, Jr., Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Evidence for change of age shown on:

FILM No. 6 117 OCT 14 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09512

97

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Takoma

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

Georges Conv. Home.

How long in hospital or institution? 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro. Geo.

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4205 Sheridan St. Hy., Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Bettie Belle Crosthwait.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	W.

6.(b) Name of husband or wife: Edwin Crosthwait

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1882

8. AGE: Years	Months	Days	If less than one day
76	7 5		..... hrs. ..... min.

9. Birthplace: [illegible]. Va. (Town, county, and state)

10. Usual occupation: House Wife.

11. Industry or business:

FATHER

12. Name: Wm. Dalby.

13. Birthplace: Va

MOTHER

14. Maiden name: ?

15. Birthplace: Va.

16. Informant: Hosp. Records.

Address: Takoma Park. Md.

17. Burial, cremation, or removal. Which?: Removal. Date thereof: Sept 6, 1948 (month) (day) (year)

Cemetery or crematory: Hyattsville, Bowie's Funeral Home

Location: Hyattsville Md.

18. Funeral director: J. Rankin & Sons.

Address: Hyattsville Md.

19. Sept 6 1948 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 September 1948 at 3 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 1948 to 6 Sept. 1948 and that I last saw her alive on 6 September 1948

	DURATION
Immediate cause of death: Acute Pulmonary Edema	24 hrs.
Due to: Acute Cardiac Failure	48 hrs.
Due to: Arteriosclerosis Generalized	8-10 yrs.
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: [signature] M. D.

M. D. or other

Address: Takoma Park, Md Date signed: 6 Sept. 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09513

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hr. 48 min

Hospital, institution, or street address where death occurred:

Washington San & Hosp.

How long in hospital or institution? 3 hrs 48 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9307 Glenville Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dabney, Mr. Lynwood Morton

3.(b) Social Security Number: 578-05-0409

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Emma Louise Dabney

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 21, 1901

8. AGE: Years	Months	Days	If less than one day
47	4	28	..... hrs. ..... min.

9. Birthplace: Brooke, Va. (Town, county, and state)

10. Usual occupation: Insurance Agent

11. Industry or business

FATHER

12. Name: Shepherd B. Dabney

13. Birthplace: Goynea, Va.

MOTHER

14. Maiden name: Katherine Morton

15. Birthplace: Brooke, Va.

16. Informant: Mrs. Emma L. Dabney

Address: 9307 Glenville Rd., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1948 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington, D. C.

18. Funeral director: Warner & Pumphrey, Inc.

Address: 8434 Ga. Ave., Silver Spring, Md.

19. ..... 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1948 at 3:48 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 @ 9:00 AM 1948 to Sept 19 @ 3:48 1948 and that I last saw b[illegible] alive on Sept 19 @ 2:45 PM 1948

Immediate cause of death	DURATION
Respiratory paralysis	
Due to: Cerebral Hemorrhage	1½ hrs
Due to: High Blood pressure	1-3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Philip E. Jones M D

M. D. or other

Address: 8914 Colesville Rd Silver Spring, Md. Date signed: 9/19/48

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09514

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery Co
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Mont.
City or town Ch. Ch. P.O. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6405 - Beechwood Dr
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME BEULAH M. DAVIES

3. (b) Social Security Number 577-09-0150

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) MAY 28 - 1895 6.(c) If alive, give age years

8. AGE: Years 53 | Months | Days | If less than one day hrs. min.

9. Birthplace Ludington Mich. (Town, county, and state)
10. Usual occupation Sect'y
11. Industry or business Nat Crushed Stone Ass'n
FATHER 12. Name John H. Davies
13. Birthplace Del.
MOTHER 14. Maiden name Bina Gale
15. Birthplace Mich.
16. Informant Alice Davies Goldbeck
Address 6405 Beechwood
17. CREMATION (Burial, cremation, or removal. Which?) Date thereof SEPT. 17 1948 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, Md.
18. Funeral director Jos. Gawler's Sons
Address 1750 Pa Ave N.W.
19. 9/16 1948 Wm E Jolley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1948, at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; That I attended deceased from 12-1- 1948, to 9/15 1948
and that I last saw h[illegible] alive on 9/14/48 1948
Immediate cause of death - Cancer of Rt Breast - DURATION 1 yr.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Benjamin Goldbeck M.D.
M. D. or other
Address 1900 F St NW. Date signed 9/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09515

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Germantown, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Fifty Years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Germantown, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mittie Duffin

3.(b) Social Security Number: NO

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): (Unknown) 1853?

8. AGE: Years	Months	Days	If less than one day
95?	0	0	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Mikel Warren
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Clara Plummer
Address: Germantown, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1. 1948 (month) (day) (year)
Cemetery or crematory: John Wesley
Location: Rockey Hill MD

18. Funeral director: Roy W. Barber
Address: Laytonsville, MD.

19. Sept. 30 1948 (Date rec'd by registrar) Alruda L Corke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept-28- 1948 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug-4- 1948 to Sept-28- 1948 and that I last saw h alive on Sept-28- 1948

Immediate cause of death	DURATION
Cardio-nephritis	1½ month
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: William C. Hilleary, M.D.
M. D. or other
Address: Gaithersburg, Md. Date signed 9/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09516

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Birth

Hospital, institution, or street address where death occurred: Suburban Hospital, Old Geo. Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8113- Grove ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ~~Infant~~ MARTIN EUGENE ~~Boy~~ Easter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 20, 1948

8. AGE:

Years	Months	Days	If less than one day
			6 hrs. 7 min.

9. Birthplace: Bethesda, Montgomery, Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Redrick Kline Easter

13. Birthplace: Amelia Virginia

MOTHER

14. Maiden name: Doris Mae Ball

15. Birthplace: Liverpool England.

16. Informant: Redrick Kline Easter

Address: 8113- Grove St. Sil. Spr. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9—48 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: Arthur B. Solon Sup't

Address: Suburban Hospital

19. 9/21/1948 (Date rec'd by registrar) W. E. Jones C. M. E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1948, at 12:40 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 20 1948, to Sept 20 1948 and that I last saw him alive on Sept 20 1948

	DURATION
Immediate cause of death: Respiratory Failure	
Due to: Prematurity (5 mos) 1 lb. 13 oz.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other

Address: 8245 Fenton Silver Spring, Md. Date signed 9-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Suburban Hospital

Bethesda, Maryland

ARTHUR B. SOLON, Superintendent

Telephone Oliver 6700

8600 Old Georgetown Road

September 21, 1948

Mr. W. E. Jobes,
512 Maple Ridge Road,
Bethesda, Md.

Dear Mr. Jobes:

I am enclosing death certificate on Baby Boy Easter, premature infant, who died September 20th. The family has requested the hospital to make disposal of the body and I will appreciate your sending me burial permit.

Very truly yours,

Laura E. Procter

Record Librarian

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09517

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Montgomery County General Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie L Easton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed

6.(b) Name of husband or wife: Harry S. Easton
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): November 10, 1878

8. AGE: Years	Months	Days	If less than one day
69	10	24	hrs. min.

9. Birthplace: Simpsonville Howard Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Owen Disney
13. Birthplace: Ann Arundel County

MOTHER
14. Maiden name: Mary Elizabeth Johnson
15. Birthplace: Montgomery County

16. Informant: Mrs Elizabeth Ward
Address: Sandy Spring, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24-1948 (month) (day) (year)
Cemetery or crematory: Friends
Location: Sandy Spring MD.

18. Funeral director: Roy W Barber
Address: Laytonsville Md

19. Sept 26 1948 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23, 1948, at 10 AM PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23, 1948 to September 23, 1948 and that I last saw her alive on September 23, 1948

Immediate cause of death	DURATION
Coronary occlusion	4 days
Due to: Coronary Sclerosis	? years
Due to:	
Other conditions: Hypertensive Cardio-Vascular Disease (Include pregnancy within 3 months of death)	? years

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert L. Williams M. D. or other
Address: Olney Md Date signed: 9-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09518

472

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 13 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7708 12th St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: FOLGER, Lester Mitchell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Sarah F. Folger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	2	18		

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: Retired Marine Corps

11. Industry or business

FATHER

12. Name: FOLGER, Isaac H. dec.

13. Birthplace: Mass.

MOTHER

14. Maiden name: DODSON, Permelia dec.

15. Birthplace: Ohio

16. Informant: wife: Mrs. Sarah F. Folger

Address: 7708 12th St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9-28-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES

Address: 2901 14th St., N. W., Wash., D.C.

19. 9-24 (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 September 19 48 at 5:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 May 19 48 to 24 Sept. 19 48 and that I last saw him alive on 24 September 19 48

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to Carcinoma right lung	6 mos
Due to	
Other conditions Senility. Arteriosclerosis generalized advanced. (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. E. NARDINI, Cdr. MC USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 9-24-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Correction of birth date authorized by letter from Dr. Cooperman. Film G-117 10/26/48. Bureau of V.S. per C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0951-3

83a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Dist of Col. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1312 Kalmia Rd. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: FRAZIER, Benjamin William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White US	Married

6.(b) Name of husband or wife: Whillametta Frazier

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-19-92 2-18-92

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	6	27		

9. Birthplace: Tenn. (Town, county, and state)

10. Usual occupation: Educator

11. Industry or business:

FATHER — 12. Name: Benjamin B. Frazier Dec

13. Birthplace: Tenn.

MOTHER — 14. Maiden name: Mary Kate Ritchie

15. Birthplace: Tenn.

16. Informant: Wife: Mrs. Whillametta Frazier

Address: 1312 Kalmia Rd. N.W. Wash. D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-17-48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Maryland

18. Funeral director: S. H. HINES FUNERAL DIRECTOR

Address: 2901 14th St. N.W. Wash. D.C.

19. 9-15- 48 (Date rec'd by registrar) Mary C. Patterson Registrar

Mary C. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 September 1948 at 02:53A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-9-48 1948 to 9-15 1948 and that I last saw him alive on 9-15-48 1948

Immediate cause of death	DURATION
Hemorrhage, Cerebellum	6 days
Due to	
Due to	
Other conditions: Pneumonia, Broncho	4 days

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. COOPERMAN CDR. MC USN
(M.D. or Coroner)

Address: U. S. Naval Hosp. Beth. Md. Date signed: 9-15-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09520

55e

CERTIFICATE OF DEATH

Reg. Dist. No. 229

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County

City or town Tunkhannock
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Gay, Mrs. Elizabeth Stonier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Marble C. Gay, Jr.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1901

8. AGE: Years	Months	Days	If less than one day
47	5	26	hrs. min.

9. Birthplace Tunkhannock, Pa.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name William Henry Stonier
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Emmadella Kayes
15. Birthplace New York

16. Informant Washington Sanitarium & Hosp. Records
Address Takoma Park, Maryland

17. Burial Date thereof Sept 7, 1948.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Tunkhannock, Penna.

18. Funeral director Gibbs Gables.

Address 237 Carroll St. Takoma Park, D.C.

19. Sept. 5 1948 J. Wm. Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 5 1948, to Sept 4 1948

and that I last saw deceased alive on Sept 4 1948

Immediate cause of death: Acute Glomerular Nephritis — DURATION: 1 mo

Due to: Generalized Carcinomatosis — 1 yr.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edna F. Patterson M.D.
M. D. or other

Address 9500 Georgia Ave. Silver Spg. Md. Date signed 9-4-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 B 09521

Reg. Dist. No. Y14

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
815 Sligo Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 Sligo Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ALICE MATILDA GAYLOR

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Edward A. Gaylor

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1890

8. AGE: Years	Months	Days	If less than one day
58	2	23	hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Real Estate Broker

11. Industry or business

FATHER 12. Name Charles P. Owens

13. Birthplace Md.

MOTHER 14. Maiden name Sarah Jane Shaw

15. Birthplace Md.

16. Informant Edward A. Gaylor

Address 815 Sligo Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27, 1948 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D. C.

18. Funeral director Warner E. Pumphrey, Inc.

Address 8434 Ga. Ave., Silver Spring, Md.

19 Sept 25 19 48 Josephine M. Schaeffe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 19 48, at 5:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-14- 19 48, to 9-24- 19 48 and that I last saw h. alive on 9-24 19 48

Immediate cause of death	DURATION
Adenocarcinoma Uterus	1946
Due to	
Due to	
Other conditions Generalized metastases (adenocarcinomatosis) (Include pregnancy within 3 months of death)	1948

Major findings of operations Hysterectomy Date of op. 7-29-48

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Shoemaker M.D.
M. D. or other

Address 8005 Woodbury Dr., Silver Spring, Md. Date signed 9-24-48

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09522

159

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: The Montgomery County General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lincoln Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Gibbs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 24, 1948

8. AGE: Years	Months	Days	If less than one day
			11 hrs. min.

9. Birthplace Olney, Montgomery Co., Md.
(Town, county, and state)
10. Usual occupation Infant.
11. Industry or business

FATHER
12. Name Lloyd Hall Jr.
13. Birthplace Rockville, Md.

MOTHER
14. Maiden name Edna Rebecca Gibbs
15. Birthplace Clarksburg, Maryland.

16. Informant Hospital Records.
Address

17. Buried Date thereof Sept 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Lincoln Park.
Location Rockville, Md.
18. Funeral director R. L. Saunders
Address Rockville, Md.

19. 9-28 1948 Gertrude B Lawson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1948, at 9 29 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1948, to Sept. 25 1948 and that I last saw h-- alive on September 25 1948

Immediate cause of death	DURATION
Respiratory paralysis	11 hr
Due to Cerebral anoxia	11 hrs
Due to Premature birth 3 5 wks (Gestation)	11 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. H. Lyon M.D.
M. D. or other
Address Sandy Spring, Md Date signed 9/25/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use of margin is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09523

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs

Hospital, Institution, or street address where death occurred: 8600 old Georgetown Rd; Suburban Hospital

How long in hospital or Institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural - Burtonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural - Near Burtonsville, Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Alice M. Gore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Thomas N. Gore

6.(c) If alive, give age: X years

7. Birth date of deceased (mo., day, yr.): June 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	2	17	6 hrs. 15 min.

9. Birthplace: Burtonsville, Montgomery Co., Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Franklin M. Kinsey

13. Birthplace: X, Maryland

MOTHER — 14. Maiden name: Harriet R. Marlowe

15. Birthplace: X, Maryland

16. Informant: Thomas N. Gore

Address: Burtonsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13/48 (Month) (day) (year)

Cemetery or crematory: Union Cmty

Location: Burtonsville, Md.

18. Funeral director: Mc Kitterick Sheldon

Address: Laurel, Md.

19. 9/10 (Date rec'd by registrar) 1948 W M E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-10-48 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1-48 19..., to 9-10-48 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Myocardial Infarction — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James E. Boyland, M.D. M. D. or other

Address: Suburban Hosp. Date signed: 9-10-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09524

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 7-14

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
County Montgomery
City or town RURAL - Ednor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 Seaton St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Timothy Joseph GORMAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Catherine A. Gorman
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 19, 1859

8. AGE: Years	Months	Days	If less than one day
88	9	11	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation Tailor
11. Industry or business —

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden name Mary Cassidy
15. Birthplace ?

16. Informant Mrs. Henry Kunold
Address Ednor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4, 1948 (month) (day) (year)
Cemetery or crematory Mt Olivet Cemetery
Location Washington D.C.
18. Funeral director John J. Mattingly
Address 131-11 [illegible] St NE Washington DC
19. Oct 30 1948 (Date rec'd by registrar) Josephine M. Schaffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1948 at 9.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1947 to September 1948 and that I last saw h..im..alive on September 21 1948

Immediate cause of death	DURATION
Coronary Thrombosis	10 min.
Due to	
Due to	
Other conditions Senility	
Hypertrophy of Prostate	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard A. Yates, M.D.
M. D. or other
Address RFD #1 Silver Spring Md. Date signed 9/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09525

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 414

1. PLACE OF DEATH:

County Montgomery

City or town RURAL - Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? not 15 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural - Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Layhill

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elmer McKinley HARRELL

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 4, 1896

8. AGE: Years 51 | Months 9 | Days 30 | If less than one day ... hrs. ... min.

9. Birthplace near Rockville Montgomery, Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER 12. Name Charles I. Harrell

13. Birthplace Virginia.

MOTHER 14. Maiden name Mary M. Robey

15. Birthplace Virginia.

16. Informant Mrs. Charles I. Harrell

Address Rt 1 Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 7, 1948 (month) (day) (year)

Cemetery or crematory Arlington National

Location Fort Myer, Va.

18. Funeral director Warner E. Pumphrey, Inc.

Address Silver Spring, Md.

19. Sept 5 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948, to Sept. 3 1948 and that I last saw him alive on August 27 1948

	DURATION
Immediate cause of death: Coronary Thrombosis	15 min.
Due to: Complicated by: Malnutrition	3 wks.
Due to: Schizophrenia	25 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard A. Yates M. D.

M. D. or other

Address Rt 1 Silver Spring, Md. Date signed 9/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

09526

CERTIFICATE OF DEATH

Reg. Dist. No. 236

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 16 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1833 Providence St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI ✓

3.(a) FULL NAME: HARRIS, Joshua

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	separated

6.(b) Name of husband or wife: Mrs. Sadie Harris
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 29, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	0	25		

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Engineer (Steam)
11. Industry or business: Veterans Administration

FATHER
12. Name: HARRIS, Robert, dec
13. Birthplace: Va.

MOTHER
14. Maiden name: REED, Fanny dec.
15. Birthplace: Va.

16. Informant: sister: Miss Lilly Harris
Address: 1833 Providence St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9-28-48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: H. Ernest Jarvis
Address: 1432 U St., N. W., Wash., D.C.

19. 9-24 (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 September 19 48 at 9: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 June 19 48 to 25 Sept. 19 48 and that I last saw him alive on 24 September 19 48

	DURATION
Immediate cause of death: Cachexia	3 months
Due to: Generalized Arteriosclerosis	4 yrs
Due to:	
Other conditions: absence acquired, left lover leg	3 months

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

H. B. EISBERG, Cdr. MC USN
23. SIGNATURE ..... M. D. or other
Address: US NH Bethesda, Md. Date signed: 9-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09527

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 8855 Piney Branch Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8855 Piney Branch Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles albert Harvey

3.(b) Social Security Number: 213-12-1218

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Annie E.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dedember 22, 1869

8. AGE: Years	Months	Days	If less than one day
78	9	7	..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Thomas Harvey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia Ann Adams
15. Birthplace: Washington, D.C.

16. Informant: Mr. Edgar C. Harvey
Address: Silver Spring, Md. R.F.D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1, 1948 (month) (day) (year)
Cemetery or crematory: Grace Episcopal Church
Location: Woodside, Md.

18. Funeral director: Warner E. Pumphrey, Inc.
Address: 8434 Ga. Ave. Silver Spring, Md.

19. Sept. 29 1948 (Date rec'd by registrar) Josephine Schaefle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1948 at 5:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to Sept 29 1948 and that I last saw him alive on June 1948

Immediate cause of death	DURATION
Coronary occlusion	
Due to: " Heart disease	1 year
Due to: Hypertension	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other
Address: 601 Colesville Rd Silver Spring Md. Date signed: 9-29-48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09528

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred: 7 Grafton st., Chevy Chase, Md
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Mont
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7 Grafton st.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna C Hawkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years: 48 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: maid

11. Industry or business:

FATHER
12. Name: John H Dorsey
13. Birthplace: Charles Co - Md

MOTHER
14. Maiden name: Rosa Jackson
15. Birthplace: md

16. Informant: Maurice Dorsey
Address: 422 M St., S.E. Wash DC.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-28-48 (month) (day) (year)

Cemetery or crematory: Lincoln Memorial Cemetery
Location: Suitland Rd., Prince George County

18. Funeral director: Barnes & Matthews
Address: 614-4" St. S.W.

19. Sept. 24 1948 (Date rec'd by registrar) Mary C. Patterson Registrar
Mary C Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1948, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 med 3 times 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary disease	Found dead in bed
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other
Address: Gaithersburg Md Date signed: 9-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

0952?

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
9 Thayer Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Thayer Place
(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3.(a) FULL NAME

JOSEPH T. HOOPES

3.(b) Social Security Number

Nca

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Clara C. Hoopes 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1900

8. AGE: Years	Months	Days	If less than one day
47	9	21	..... hrs. ..... min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Route Supervisor

11. Industry or business: Colonial Baking Company

FATHER
12. Name: Clement D. Hoopes
13. Birthplace: West Chester, Pa.

MOTHER
14. Maiden name: Martha Fletcher Price
15. Birthplace: Harford Co., Md.

16. Informant: Rupert Lee Hoopes, brother
Address: R. #3, Bethesda, 14, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 9/20/48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Va.

18. Funeral director: Lee Funeral Home
Address: 300-4th N.E. Washington

19. Sept 16 19 48 (Date rec'd by registrar) Josephine M. Schaaf Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 19 48 at 2:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 to Sept 16 19 48 and that I last saw him alive on Sept 16 19 48

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bosehart M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 9-16-48

PLEASE WRITE PLAINLY, with UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 09530

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist. of Col. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1014 Taussig Place N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II ✓

3.(a) FULL NAME

HUGHES, Charles Evans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W - U.S.	Married

6.(b) Name of husband or wife: Marion Hughes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-24-16

8. AGE: Years	Months	Days	If less than one day
31	11	23	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Instructor in flying.

11. Industry or business

FATHER — 12. Name: Charles Hughes

13. Birthplace: Washington, D. C.

MOTHER — 14. Maiden name: Thresa Newheiser

15. Birthplace: Washington, D. C.

16. Informant: Wife; Mrs. Marion Hughes

Address: 1014 Taussig Place N.E. Wash. D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-21-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Warner E. Pumphrey D.C.N.D.

Address: 8434 Georgia Ave. Silver Spring, Md.

19. 9-17 1948 (Date rec'd by registrar)

Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 September 1948, at 11:13 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 September 1948 to 17 Sept. 1948 and that I last saw him alive on 17 September 1948

Immediate cause of death	DURATION
Chorio-epithelioma of testis	
with generalized metastases	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. N. WEBSTER LTJG MC USN
M. D. or other

Address: U.S.N.Hosp., Bethesda, Md. Date signed: 9-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09531

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred: Montgomery County General Hospital
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RT #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS LAMAR JACKSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Jackson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 28, 1873

8. AGE:

Years	Months	Days	If less than one day
74	8	18	hrs. min.

9. Birthplace: Hyattsville Prince Georges Maryland (Town, county, and state)
10. Usual occupation: Stock Breeder
11. Industry or business

FATHER
12. Name: Thomas D. Jackson
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden name: Ada Fawcke
15. Birthplace: Warrenton Virginia

16. Informant: Mrs. Elizabeth Jackson
Address: Silver Spring, Md. RT #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1948 (month) (day) (year)
Cemetery or crematory: Colesville Cemetery
Location: Colesville, Md.
18. Funeral director: Warner E. Pumphrey, Inc.
Address: Silver Spring, Md.
Burial permit issued by Josephine Schaeffer
19. Sept 22 1948 Gertrude B. Lawlor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16, 1948, at 1:38 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31, 1948 to September 16, 1948 and that I last saw him alive on September 16, 1948

Immediate cause of death	DURATION
Coronary Occlusion	1 hour
Due to: Recent Coronary Occlusion	17 days
Due to: Coronary Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Bird M. D. or other
Address: Sandy Spring, Md. Date signed: 9/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09532

46a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months 11 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 Months 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Mont.

City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

KEBIL, Paul Blashiar

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Hannah Kebil

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): September 17, 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	11	26		

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Boatmaker

11. Industry or business

FATHER
12. Name: George J. Kebil Dec.
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Ema Fissel Dec.
15. Birthplace: Pennsylvania

16. Informant: Wife: Mrs Hannah Kebil,
Address: Seneca, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-17-48 (month) (day) (year)

Cemetery or crematory: Gettysburg National Cemetery

Location: Gettysburg, Pennsylvania

18. Funeral director: W W Chambers Omk.

Address: 1400 Chapin St NW Washington, D.C.

19. 9-14 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 September 1948, at 11:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2, July 1948 to 13 Sept. 1948 and that I last saw him alive on 13 September 1948

Immediate cause of death	Duration
Pneumonia, Broncho	4 days
Due to: Cachexia, Extreme	3 Mo
Due to: Carcinoma of Esophagus Epidermoid type	Indef
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: L. E. Watters LTJG MC USN
M. D. or other

Address: USNH, Bethesda, Md. Date signed 9-14-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09533

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs
Hospital, institution, or street address where death occurred:
204 W. Leland St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bkvn Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 W. Leland Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cora Mae Kline

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1872

8. AGE: Years	Months	Days	If less than one day
76	3	17	hrs. min.

9. Birthplace CHAMBERSBURG, PENNA. (Town, county, and state)
10. Usual occupation AT HOME
11. Industry or business
FATHER 12. Name RAFE SNYDER
13. Birthplace Pa
MOTHER 14. Maiden name Emma F Hawbaker
15. Birthplace Pa
16. Informant Ruth Kline daw
Address Leland St
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14 1948 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland, Maryland
18. Funeral director Jos Gawler's Sons
Address 1756 Pa. Ave. N.W. - D.C.
19. 9/11 1948 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 1948 to Sept 11 1948 and that I last saw h. alive on Sept 9th 1948

Immediate cause of death	DURATION
Cardiovascular Renal Disease	Chronic
Due to	
Due to	
Other conditions Rheumatoid Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank L Wellman M. D. or Coroner
Address 2731 Conn Ave Washington D.C. Date signed 9-11-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45

11-3-94

1872-5-29

X-X-1948

8-41

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09534

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 832 Gist Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3.(a) FULL NAME: WILLIAM ERNEST LAMBERT

3.(b) Social Security Number: 578-07-4647

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Blanche Rose

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	19	____ hrs. ____ min.

9. Birthplace: Point of Rocks, Md.
(Town, county, and state)

10. Usual occupation: Cashier

11. Industry or business: Cherner Motor Co.

FATHER
12. Name: Frank Lambert
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: N

16. Informant: Mrs. Blanche Rose Lambert

Address: 832 Gist Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1948 (month) (day) (year)

Cemetery or crematory: Colesville Cemetery

Location: Colesville, Md.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: Silver Spring, Md.

19. 9/23 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 1948, at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1947, to Sept. 15 1948 and that I last saw him alive on Sept. 15 1948

Immediate cause of death	DURATION
Myocardial Infarction	3 days
Due to: Coronary Atherosclerosis	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

L. B. Snow

23. SIGNATURE: L. B. Snow M.D. M. D. or other

Address: Silver Spring, Md. Date signed: 9-15-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

200a

09535

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hours 9 minutes
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 8 hrs. - 9 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4935 Cordell Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME ~~Infant Girl~~ BARBARA LYNN Lanier

3.(b) Social Security Number None

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: newborn

6.(b) Name of husband or wife None

6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Sept-16, 1948.

8. AGE: Years 8hrs | Months 0 | Days 0 | If less than one day 8 hrs. 9 min.

9. Birthplace Bethesda, Mont. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name Carlos h. Lanier

13. Birthplace Savannah, Georgia

MOTHER 14. Maiden name Jane Cragg

15. Birthplace DuBois, Penna.

16. Informant Father

Address Same

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/27/48 (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D.C.

18. Funeral director W. Reuben Humphrey

Address Bethesda, Maryland

19. Sept 21 1948 (Date rec'd by registrar) Mrs E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948 at 4 54 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 16 1948 to Sept 16 1948 and that I last saw h.r alive on Sept 16 1948

	DURATION
Immediate cause of death Cerebral Edema	
Due to (Traumatic) Accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Dwyer M.D.
M. D. or other
Address Bethesda, Md. Date signed 9-17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09536

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Monty Co —
City or town: Kensington Md —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Yrs —
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Monty
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Larman (Henry Milton)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 23rd — 1885

8. AGE: Years	Months	Days	If less than one day
1885 63	6	6	hrs. min.

9. Birthplace: Monty Co. Md.
(town, county, and state)

10. Usual occupation: Labour —

11. Industry or business: c.

FATHER
12. Name: James Larman
13. Birthplace: Md —

MOTHER
14. Maiden name: Elizabeth Thompson
15. Birthplace: Md —

16. Informant: Gertrude King —
Address: Gaithersburg Md —

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/48 (month) (day) (year)

Cemetery or crematory: Monocacy Cemetery
Location: Redbirdville Md.

18. Funeral director: D. C. Gaither
Address: Gaithersburg Md

19. Oct. 1 1948 (Date rec'd by registrar) Alenda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/29/48 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 19..... to 9/29/48 19.....
and that I last saw h.i.m. alive on 9/27/48 19.....

Immediate cause of death	DURATION
Coronary Occlusion	15 min
Due to Arteriosclerosis	yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Samuel Allen M.D.
M. D. or other
Address: Kensington Md Date signed 9/29/48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

09537

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Bladensburg, Cabin
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Minn. County: Stillwater
City or town: Stillwater
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World Wars 1 and 2 Army-Navy

3.(a) FULL NAME: Otis L. Maes

3.(b) Social Security Number: YES

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth L. Maes
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): November 15, 1899

8. AGE: Years	Months	Days	If less than one day
48 48	10	4	hrs. min.

9. Birthplace: Ridgeway, Wisconsin (Town, county, and state)
10. Usual occupation: Mail Carrier
11. Industry or business: U.S. Government

FATHER
12. Name: Alonzo D. Maes
13. Birthplace: Unknown

MOTHER
14. Maiden name: Barbara Winters
15. Birthplace: Unknown

16. Informant: Wife Mrs Ruth Maes
Address: Rockville, Maryland

17. Burial-Transit (Burial, cremation, or removal. Which?) Date thereof: 9/20/48 (month) (day) (year)
Cemetery or crematory: Stillwater, Minnisota
Location: Stillwater, Minnisota

18. Funeral director: Mc Reuben Peacock
Address: 7557 Wisconsin Avenue

19. Sept 20, 1948 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1948 at 3:45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1948 to Sept 19 1948 and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary occlusion	died suddenly
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bosshart M. D. Med Exam M. D. or other
Address: Gaithersburg Md Date signed: 9-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09538

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

205 Hodges Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Hodges Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marie L. Manchester

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	married

6.(b) Name of husband or wife: Allen W. Manchester

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): JAN. 13, 1886

8. AGE:

Years	Months	Days	If less than one day
62	7	27	hrs. min.

9. Birthplace: Halstead Minn.

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: — Lovsness

13. Birthplace: Norway

MOTHER

14. Maiden name: Mali Sethum

15. Birthplace: Norway

16. Informant: Allen W. Manchester

Address: 205 Hodges La. Takoma Pk, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1948 (month) (day) (year)

Cemetery or crematory

Location: Washington, D. C.

18. Funeral director: D. H. Hines Co.

Address: 2901-14th St. N.W. - D.C.

19. Sept. 10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Sept 10 1948

and that I last saw h alive on Sept 10 1948

Immediate cause of death	DURATION
Coronary occlusion	5 min
Due to	suddenly
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bosechart M.D. Dept Med Exam M. D. or other

Address: Gaithersburg Md Date signed: 9-10-48

M

I

MARGIN RESERVED FOR BINDING

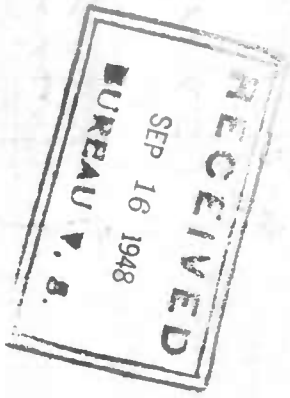
PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

1948-8-40

62-7-27

1986-1-13



Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0953

13 1a

FILM No. G 1170CT 8 1948 **CERTIFICATE OF DEATH**

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Wesley Marr (MARR)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	C	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 15 1888

8. AGE: Years	Months	Days	If less than one day
59 ## 60	11		..... hrs. ..... min.

9. Birthplace Va
(Town, county, and state)
10. Usual occupation Labor
11. Industry or business

FATHER
12. Name John Marr
13. Birthplace Va

MOTHER
14. Maiden name Nellie Brown
15. Birthplace Va

16. Informant Bessie Hall Daughter
Address Sandy Spring Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Sept 28 1948
(month) (day) (year)
Cemetery or crematory Westlawn mem
Location Wheaton, Md.

18. Funeral director Robert L Snowden
Address Rockville Md

19. 9-28 1948 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1948, at 4:47 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 13 1934 to September 24 1948 and that I last saw h. alive on Sept 21 1948

Immediate cause of death	DURATION
Chronic Nephritis	
without Oedema,	
Due to Hypertension	
Arteriosclerosis	
Due to	
Other conditions Coronary Disease	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Webster Sewell, M.D.
M. D. or other
Address Norbeck Md. Date signed 9-27-48

VS A15 9-45-15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

145

Reg. Dist. No. 0954 1215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: St Marys

City or town: Lexington Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Adams Avenue, Carver Heights
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MAYFIELD, Mary Elizabeth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col-US	married

6.(b) Name of husband or wife: Henry Mayfield, ST2 USN

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 17, 1923

8. AGE: Years	Months	Days	If less than one day
25	2	9	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: FRIEND, Oscar dec.
13. Birthplace: Pa.

MOTHER
14. Maiden name: SHOWELL, Rida
15. Birthplace: Md.

16. Informant: husband: Henry Mayfield, ST2 USN

Address: 20 Adams Avenue, Carver Heights, Lexington Park, Md.

17. burial — Date thereof ____ (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Mt. Olive

Location: Wilmington, Del.

18. Funeral director: Austin O. Caulk A O C

Address: 827 Pine St., Wilmington, Del.

19. 9-28 1948 Mary C. Patterson Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 September 1948 at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 September 1948 to 26 Sept. 1948 and that I last saw h... alive on 26 Sept. 1948

	DURATION
Immediate cause of death: Hydatidiform mole	4 mo.
Due to: acute cardiac failure	Sudden
Due to: Hemorrhage into adrenals	Sudden
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Fulminating hemorrhagic necrosis of ovary, mole in uterus Date of op. 9/23/48

Autopsy results: Confirmed the above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

Paul Peterson

23. SIGNATURE: PAUL PETERSON, Captain MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

109 A 09541

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg. Co.

City or town: Washington Grove Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Mont.

City or town: Wash. Gro.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Belle McCathran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: James E. McCathran

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov 6 1868

8. AGE: Years	Months	Days	If less than one day
79	10	1	hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: —

FATHER — 12. Name: James T. Harper

13. Birthplace: Washington DC

MOTHER — 14. Maiden name: Eliza J. Rollins

15. Birthplace: Washington DC

16. Informant: Irving F. McCathran

Address: Washington Grove Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9/9/48 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md.

18. Funeral director: E. G. Gartrell

Address: Gaithersburg Md.

19. Sept. 8 1948 Alverda G. Cooke (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1948 at 8:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Sept. 7 1948 and that I last saw her alive on Sept. 6 1948

Immediate cause of death	DURATION
Senility	
general debility	
Chronic nephritis	
Due to: Acute pneumonia 8-14-48 to 8-24-48	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Miller, M.D. M. D. or other

Address: Gaithersburg, Md. Date signed: 9-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09542

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8704 Colesville Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8704 Colesville Road, Apt. 205
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Mangum McLeod

3.(b) Social Security Number: 578-05-0409

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Irene B. McLeod

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 23, 1884

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	4	26		

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Construction Superintendent

11. Industry or business

FATHER
12. Name: Robert McLeod
13. Birthplace: Scotland

MOTHER
14. Maiden name: Christina Monroe
15. Birthplace: Scotland

16. Informant: Mrs. Irene B. McLeod
Address: 8704 Colesville Road, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Bladensburg Rd., Md.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: 8434 Ga. Ave., Silver Spring, Md.

19. Sept 20 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1948, at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1948 to Sept 19 1948

and that I last saw h alive on Sept 19 1948

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broccard M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 9-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

09543

Reg. Dist. No. 227

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred: C.R. Chestnut & Philadelphia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 150 Philadelphia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frank W. Neff Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1946

8. AGE: Years 2 | Months 1 | Days 20 | If less than one day hrs. min.

9. Birthplace Takoma Park, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER — 12. Name FRANK WILLIAM NEFF.

13. Birthplace Penna.

MOTHER — 14. Maiden name SHIRLEY MAUKIBELL

15. Birthplace St. Paul, Minnesota

16. Informant Mr. Frank William Neff, Sr.

Address 150 Philadelphia Ave. Takoma Park Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 2 1948 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Bladensburg Rd at the District Line

18. Funeral director J. Arthur Stallings

Address 254 Carroll St. N.W. Takoma Park, D.C.

19. SEP 23 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1948, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22nd 1948 to 1948

and that I last saw h alive on 1948

Immediate cause of death	DURATION
Fracture of skull	10 min.
Due to auto	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/22/48

Where did injury occur? Takoma Pk. (City or town) Mont. (County) Md. (State)

Injured at home, farm, industry, public place (where?) street

Means of injury Struck by auto Injured at work? no

23. SIGNATURE Frank J. Brochard M.D. Med. Examiner M. D. or other

Address Gaithersburg Md. Date signed 9-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09544

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Beallsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural Beallsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route no 15

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Martha Ellen Owens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	widowed

6.(b) Name of husband or wife: Dennis Owens

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11 1869

8. AGE:

Years	Months	Days	If less than one day
79	3	0	..... hrs. ..... min.

9. Birthplace: Montgomery Co. Md. (Town, county, and state)

10. Usual occupation: domestic

11. Industry or business

FATHER

12. Name: William Dorsey

13. Birthplace: Mont. County Md.

MOTHER

14. Maiden name: Ann Hamilton

15. Birthplace: Mont. County Md.

16. Informant: Mary E. Hadel

Address: Beallsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9/15/48 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Near Sellman Md

18. Funeral director: Clarence H Davis

Address: Poolesville Md

19. Sept. 13 1948 (Date rec'd by registrar) Mrs. C. C. Hilton By M.W.O.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 Sept. 1948 at 3: A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Sept 1948 to 12 Sept 1948 and that I last saw h.. alive on 11 Sept 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hrs.
Due to: Hypertension	years
Due to: Arteriosclerosis	years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J. Fawcett M.D. M. D. or other

Address: P.O. Boyd, Md. Date signed 12 Sept 48

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09545

13/a

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
831 Gist Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 831 Gist Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MATTIE PARKER

3.(b) Social Security Number

---

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife William A. Parker

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1867

8. AGE: Years	Months	Days	If less than one day
81	1	16	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

FATHER
12. Name Caleb B. Hamilton
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Clara Hogy
15. Birthplace Baltimore, Md.

16. Informant Mr. Wm. A. Parker

Address 831 Gist Ave., Silver Spring, Md.

17. Burial Date thereof Sept. 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Washington, D. C.

18. Funeral director Warner E. Pumphrey, Inc.

Address 8434 Ga. Ave., Silver Spring, Md.

19. Sept 20 1948 Josephine M. Schaeffle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948 at 8.50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1945 to Sept. 19 1948

and that I last saw h.er alive on Sept. 19 1948

Immediate cause of death Cardio-renal Vascular disease. — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J W Bullock M. D
M. D. or other

Address 766 Rock Ch. Ch. Rd Date signed Sept 19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

09546

FILM No. G 117 SEP 21 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Gallatin St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI & II

3. (a) FULL NAME: PEARSON, John Murphy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Lois Pearson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 27, 1906

8. AGE: Years	Months	Days	If less than one day
42 / 89	7	14	hrs. min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business

FATHER
12. Name: PEARSON, Wm. dec
13. Birthplace: Scotland

MOTHER
14. Maiden name: RINTOUL, Jane dec.
15. Birthplace: Scotland

16. Informant: sister: Mrs. Margaret Tripp
Address: 619 Gallatin St., N. W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-14-48 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: W.W. Chambers Funeral Home
Address: 517 11th St S E Washington DC

19. 9-11 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 September 1948 at 8:58 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 Sept. 1948 to 11 Sept. 1948 and that I last saw h... im alive on 11 Sept. 1948

Immediate cause of death	DURATION
Gastro intestinal hemmorrhage due to	10 days
Intestinal obstruction due to	
adhesions following	
resection rectum	
Other conditions: Carcinoma rectum in 1945	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. 9-8-48

Autopsy results: Confirm above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. C. Kessler R. C. KESSLER, Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 9-11-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a

09547

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 16 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6031 Utah Avenue, N. W.,

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: PEGRAM, Virgil Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Blanche Pegram

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 28, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	11	22		

9. Birthplace: N.C. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Government Printing

FATHER

12. Name: PEGRAM, Francis M. dec.

13. Birthplace: N.C.

MOTHER

14. Maiden name: PEGRAM, Elizabeth

15. Birthplace: N.C.

16. Informant: wife: Mrs. Blanche Pegram

Address: 6031 Utah Avenue, N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetary or crematory: Bethel Methodist

Location: Kernersville, N. C.

18. Funeral director: S. H. HINES S. H. Hines

Address: 2901 14th St., N. W., Wash., D.C.

19. 9-20- 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 September 1948 at 12:50A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 March 1948, to 20 Sept. 1948 and that I last saw him alive on 20 September 1948

	DURATION
Immediate cause of death: Cerebral Accident	12 hrs.
Due to: Myelogenous Leukemia (Chronic)	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

D. E. BILLMAN, Lt JG MC USN

23. SIGNATURE: M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45


RECEIVED
SEP 21 1948
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09548

50

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: 8101 Old Georgetown Road,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 8101 Old Georgetown Road, (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Mrs. Beatrice M. Perrell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Upton Perrell

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) November 27, 1893

8. AGE: Years	Months	Days	If less than one day
54 54	9	16	— hrs. — min.

9. Birthplace Montgomery County, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name Walter Haines

13. Birthplace Montgomery County, Maryland

MOTHER 14. Maiden name Eva K. Morrison

15. Birthplace Pennslyvania

16. Informant Jack Perrell (son)

Address Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1948 (month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville, Maryland

18. Funeral director Wm. Reardon Funeral Home

Address Bethesda, Maryland

19. 9/15 1948 (Date received by registrar) Wm E Dolan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13th, 1948, at 3:03 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to Sept 1948 and that I last saw h[illegible] alive on Sept 13 1948

	DURATION
Immediate cause of death Metastasis due to	2 yrs
Due to Cancer of Breast	6 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lee L Downs M.D. M. D. or other

Address Bethesda, Maryland Date signed 9/13/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

930

09549

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda 9
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5511 Oak Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Alice Powell

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband: Robert Finley Powell
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): July 17 1860
8. AGE: Years: 88 Months: 1 Days: 28 If less than one day: ..... hrs. ..... min.
9. Birthplace: Missouri (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Moses Tisdel
13. Birthplace: Missouri
MOTHER 14. Maiden name: Sarah ?
15. Birthplace: Missouri
16. Informant: Mrs Ivy Norton
Address: Fairhope alabama
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9-15-48 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg Road
18. Funeral director: The S. H. Hines Co.
Address: 2901-14th St. N.W.
19. 9/14 1948 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1948 at 7 45' M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 14 1948 and that I last saw h.. alive on Sept 14 1948

	DURATION
Immediate cause of death: Hypertensive heart decay	
Due to: Hypertension	
Due to:	
Other conditions: Colitis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph P. Kinch M. D. or other
Address: 7742 Wisconsin Ave. Date signed 9/14/48
Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

09550

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH.

County: Monty

City or town: Travilah

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Feb. 1, 1948

Hospital, institution, or street address where death occurred:

R.F.D. Rockville Md.

How long in hospital or institution? Since Feb. 1, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: D.C.

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3149 Mt. Pleasant St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Ida C. Presgrave

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Eugene W. Presgrave

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 13, 1857

8. AGE: Years	Months	Days	If less than one day
90 90	11	25	..... hrs. ..... min.

9. Birthplace: Arcola Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Richard Bradshaw

13. Birthplace: Arcola, Va.

MOTHER

14. Maiden name: Rebecca W. Ayre

15. Birthplace: Leesburg, Virginia

16. Informant: Mrs May L. Is bell

Address: Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/10/48 (month) (day) (year)

Cemetery or crematory: Mt Zion Cemetery

Location: Adiq, Virginia

18. Funeral director: Wm Rawlings Dempsey

Address: Bethesda, Maryland

19. Sept. 10, 1948 (Date rec'd by registrar) E.P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Extensive burns	died Sept 8
Due to home fire (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 9-8-48

Where did injury occur? Travilah (City or town) Monty (County) md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury burns Injured at work? no

23. SIGNATURE: Frank J. Bosshart M.D. Sept 8 1948 M. D. or other

Address: Gaithersburg md Date signed 9-9-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

09551

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 22 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington County:

City or town: District of Columbia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 504 6th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME

James Arthur PRICE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 1, 1893

8. AGE: Years	Months	Days	If less than one day
54	10	3	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Contracting Work

11. Industry or business:

FATHER
12. Name: PRICE, Henry
13. Birthplace: Md.

MOTHER
14. Maiden name: YOUNG, Julia
15. Birthplace: Md.

16. Informant: sister: Mrs. Mary Thomas

Address: 504 6th St., N.E., Wash., D.C.

17. burial — Date thereof: 9-9-48 (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U. St., NW, Wash., D.C.

19. 9-4- 1948 — Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 September 1948, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 May 1948 to 4 Sept. 1948 and that I last saw him alive on 4 Sept. 1948

	DURATION
Immediate cause of death: Cachexia	2 mons.
Due to: Carcinoma, Pancreas	9 mons.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. R. Cooper, Lt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-4-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Undertaker's application micro-filmed 10/6/48 - G117-L

09552

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred: 65 Decatur Street, Kensington, Md.

How long in hospital or institution? Died at Home

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington (if outside city or town limits, write RURAL and give nearest town)

Street No. 65 Decatur Street (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Pugh, Nannie Susan.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M.

6.(b) Name of husband or wife: Lewis Nichols Pugh

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): March 3, 1870

8. AGE: Years	Months	Days	If less than one day
78	6	26	hrs. min.

9. Birthplace: Virginia Town & County Unknown (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Robert Witt

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Julia Newton

MOTHER — 15. Birthplace: Virginia

16. Informant: Lewis Nichols (Husband)

Address: 65 Decatur Street, Kensington

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/2/48 (month) (day) (year)

Cemetery or crematory: Presbyterian Cemetery

Location: Bethesda, Maryland

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wisconsin Ave. Beth.

19. 9/30 19 48 W. E. Johns Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: (Sept.) 9/29/48 19 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to 9/29/48 and that I last saw h[illegible] alive on 8/25/48

Immediate cause of death	DURATION
Coronary Occlusion	1/2 hr.
Due to Arteriosclerosis Marked	yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Allen M.D. M. D. or other

Address: Kensington, Md. Date signed: 9/29/48

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 09553

Reg. Dist. No. 229

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ____ County ____
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Gallatin St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war ____

3.(a) FULL NAME Reznek Mrs Sarah

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife ____ 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) SEPT. 20, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	11	24		

9. Birthplace Russia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Louis Rajhek Samuel Reibstein
13. Birthplace Russia
MOTHER 14. Maiden name Rachel Hranekaum
15. Birthplace Russia.
16. Informant Family & Sanitarium Records.
Address Takoma Park. Maryland.
17. ____ Date thereof ____ (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory National Memorial Park
Location Washington DC
18. Funeral director Goldberg Funeral Home
Address 4717 - 9th St N W
19. 9-14 1948 ____ Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 4:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1948, to Sept 14 1948
and that I last saw her alive on Sept 13, 1948
Immediate cause of death Coronary Arteriosclerosis
Due to Arteriosclerotic Heart Disease yrs
Due to ____
Other conditions ____
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ____ Date of op. ____
Autopsy results As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Wm Vos K. Mudd M.D.
M. D. or other
Address Takoma Park Md Date signed 9-14-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1948 - 8 - 11
69 - 11 - 24
1878 - 9 - 20

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

09554

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County:

City or town: Boston
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 16 Taft W. Newton
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI ✓

3. (a) FULL NAME: RICHARDSON, John Samuel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Margurette Richardson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 9, 1890

8. AGE: Years	Months	Days	If less than one day
58	8	21	..... hrs. ..... min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: State Department Employee

11. Industry or business:

FATHER
12. Name: RICHARDSON, John S.
13. Birthplace: Maine

MOTHER
14. Maiden name: BENNETT, Minnie dec.
15. Birthplace: Maine

16. Informant: WIFE: Mrs. Margurette Richardson
Address: 16 Taft W. Newton, Boston, Mass.

17. ~~Burial~~ Removal Date thereof: Oct. 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Forest Hills
Location: Boston, Mass.

18. Funeral director: W. W. CHAMBERS
Address: 3072 M St., N. W., Wash., D.C.

19. 10-1 1948 Mary C. Patterson Mary C. Patterson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 September 1948, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 21 September, 1948 to 30 September, 1948 and that I last saw him alive on 30 September 1948

	DURATION
Immediate cause of death: Peritonitis	2 days
Due to: Perforated Peptic Ulcer	2 days
Due to:	
Other conditions: Carcinoma Left Kidney	8 Months

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jack T. Jones, Jr. Lt.(JG)MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-1-48

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

09555

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Montgomery County General Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Spencerville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mrs. Sarah RICHARDSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: George H. Richardson
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): ~~70 yrs. 0 mos.~~ Sept. 4, 1878

8. AGE: Years	Months	Days	If less than one day
70	0 yrs	10	____ hrs. ____ min.

9. Birthplace: E. Nor. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Andrew Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Harding
15. Birthplace: Maryland

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16 '48 (month) (day) (year)
Cemetery or crematory: Union
Location: Burtonsville Md
18. Funeral director: H. E. Fitzgerald Sons
Address: Laurel, Md.

19. Sept 15 1948 (Date rec'd by registrar) Gertrude B Fowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14, 1948 at 2 00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 8, 1948 to September 14, 1948 and that I last saw h.er alive on September 13, , 1948

Immediate cause of death	DURATION
Pulmonary embolism	Minutes
Due to, Coronary Occlusion	6 days
Due to, Coronary Sclerosis	? years
Other conditions Hypertensive Cardio-Vascular Disease (Include pregnancy within 3 months of death)	? years.

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Gandy Spring, Md Date signed: 9/14/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09556

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

105 Holly Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Holly Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WALTER WARREN SEELEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Hark Seeley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 24, 1872

8. AGE: Years: 76 | Months: 3 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Blackbrook, New York (Town, county, and state)

10. Usual occupation: Retired Contractor

11. Industry or business: Same

FATHER

12. Name: Warren Seeley

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Elizabeth Hark Seeley

Address: 105 Holly Ave. Tak. Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 22, 1948 (month) (day) (year)

Cemetery or crematory: Warrenton Cemetery

Location: Warrenton, Virginia

18. Funeral director: J. Arthur Walters

Address: 754 Carroll Ave. Takoma Park, D.C.

19. SEP 21 1948 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Sept. 1948, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to 20 Sept. 1948 and that I last saw him alive on 16 Sept. 1948

Immediate cause of death	DURATION
Gangrene left foot.	6 weeks.
Due to Arterio Sclerotic Vascular Disease.	8 to 10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. B. Cullen M.D. (M. D. or other)

Address: Takoma Park, Md. Date signed: 20 Sept. 1948

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1248 09557

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 days

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 76 New York ave N.W. apt 302
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Mrs Julia Neal Sheely

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Mr Harry F. Sheely

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1879

8. AGE: Years	Months	Days	If less than one day
69	11	26	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Thomas DeVaughn
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Lovell Matthews
15. Birthplace: Washington D.C.

16. Informant: Mrs. Harry F. Sheely
Address: 76 New York Ave N W Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1948 (month) (day) (year)
Cemetery or crematory: Ledon Hill Cemetery
Location: Prince Geo. Co. Md.

16. Funeral director: W. W Chamberlin & Co
Address: 517-11th St. S.E.

19. Sept 1 1948 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 1948, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1948 to Sept 1 1948 and that I last saw her alive on Sept 1 1948

Immediate cause of death	DURATION
Myocardial failure	Terminal
Due to: Anemia - primary	Months
Due to: Cirrhosis of Liver	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Cirrhosis of Liver Date of op. 8/17/48

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. G. Hyatt M.D.
By Robert A Hare M.D.
M. D. or other

Address: Takoma Park Wash. Md DC Date signed 9/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

Evidence for correction of nos. 3,9,12 shown on:

09558

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

FILM No. G 117 OCT 13 1948

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hrs - 35 min.

Hospital, Institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda, Md.

How long in hospital or institution? 12 hrs 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Raymond St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME J.

Mr/Marion T. Shull

3. (b) Social Security Number

4. Sex	5. Color or race	6. (~~Single~~, married, ~~widowed, or divorced~~)
M	W	

6.(b) Name of husband or wife Mary

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1872.

8. AGE: Years 76 | Months 7 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Clark Co. (Springfield-Near) Greenfield, Ohio
(City, town, or county, and state)

10. Usual occupation Dept. of agriculture Retired

11. Industry or business

FATHER 12. Name William Shull

13. Birthplace Harrison ? Ohio

MOTHER 14. Maiden name Catharine Ryman

15. Birthplace ? Ohio

16. Informant Francis M. Shull, N.Y.

Address 759 Landring Rd. Rochester

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-1-48 (month) (day) (year)

Cemetery or crematory

Location Washington, D. C.

18. Funeral director Chevy Chase Funeral Home

Address 5103 Wisconsin Ave. N.W. Washington - D.C. Wm E Jobes

19. 9-1-48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 48 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 48 to Sept 1st 48 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	12 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bernhart M.D.
Dept Med Exam M. D. or other

Address Gaithersburg Md. Date signed 9-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131b

09554

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Chas. Walter Sickles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Addie Sickles
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1901

8. AGE: Years 47 Months Days If less than one day hrs. min.

9. Birthplace Darnestown, Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Walter Sickles
13. Birthplace Md

MOTHER
14. Maiden name Maggie Smith
15. Birthplace Md

16. Informant Gertrude Gray
Address Rockville, Md

17. Burial Date thereof Oct. 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Dunner Orchard
Location Dunner Orchard, Md
18. Funeral director Robert L. Swayden
Address Rockville, Md

19. 10/3/48 19 E. P. Thompson
(Date rec'd by registrar) B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948 at 4.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 9/30 1948 and that I last saw h.. alive on Sept 30 1948

Immediate cause of death	Abscess of lung	DURATION
Due to		
Due to		
Other conditions	Chronic Myocarditis & Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C E Hawks M. D. or other
Address Rockville Md Date signed 10/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09560

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1507 B St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII ✓

3. (a) FULL NAME: SIMMS, George Vinson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29, 1915

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
33	1	20		

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Receiving Station, Wash., D.C.

FATHER
12. Name: SIMMS, Charles
13. Birthplace: Wash., D.C.

MOTHER
14. Maiden name: CARTER, Eleanor
15. Birthplace: Va.

16. Informant: Mother: Mrs. Eleanor Simms

Address: 1507 B St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9-22-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Stewart Funeral Home S.D.T.

Address: 30 H St., N.E., Wash., D.C.

19. 9-20- 48 (Date rec'd by registrar) Mary E. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 September 1948, at 8:16 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 August 1948 to 19 Sept. 1948 and that I last saw him alive on 19 September 1948

Immediate cause of death	DURATION
Acute Bacterial Endocarditis	4 Wks.
Staph. aureus	
Due to:	
Due to:	
Other conditions: Abscesses, lungs, bilateral from Septic Emboli. (Include pregnancy within 3 months of death)	2½ wk.

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

S. R. Mills Jr.

23. SIGNATURE: S. R. MILLS, Jr., Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-20-48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09561

CERTIFICATE OF DEATH

Reg. Dist. No. [redacted]23

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 YRS.

Hospital, institution, or street address where death occurred:

#1 MONTGOMERY AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 MONTGOMERY AVE

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DR CLARENCE BEAMAN SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: LOTTIE LEE SMITH.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT. 21, 1870.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	11	27		

9. Birthplace: HOWARDSVILLE, MICH. (Town, county, and state)

10. Usual occupation: ASSISTANT DIRECTOR EXTENSION

11. Industry or business: SERVICE, DEPT. of AGRICULTURE.

FATHER — 12. Name: ALONZO SMITH.

FATHER — 13. Birthplace: N. Y.

MOTHER — 14. Maiden name: HARRIET MAYBEE

MOTHER — 15. Birthplace: MO.

16. Informant: Miss HELEN IRENE SMITH.

Address: 1 MONTGOMERY AVE.

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof: SEPT. 21, 1948. (month) (day) (year)

Cemetery or crematory: CEDAR HILL CREMATORY.

Location: PA AVE. EXT. PR GEO. CO., Md.

18. Funeral director: J. Arthur Slatter

Address: 254 Carroll Ave., Takoma Park, D.C.

19. 9/19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1948 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 1948 to Sept. 18 1948 and that I last saw him alive on September 17 1948

Immediate cause of death	DURATION
Coronary Thrombosis	2 wks.
Due to: Arteriosclerosis	20 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SIGNATURE: Charles J. Carroll M.D. M. D. or other

Address: 6801-6th St. N.W., Wash. D.C. Date signed: 9/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

19562 213

94a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Monty

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo

Hospital, Institution, or street address where death occurred:
735 Anderson ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother):

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 735 Anderson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (a) FULL NAME Gerald R. Smith

3. (b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 20, 1909

8. AGE: Years	Months	Days	If less than one day
39 39	1	7	____ hrs. ____ min.

9. Birthplace Sutter, California
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business U. S. Navy

FATHER
12. Name Fred L. Smith
13. Birthplace Unknown

MOTHER
14. Maiden name Nell P. unknown
15. Birthplace Unknown

16. Informant U. S. Navy Discharge Papers

Address None

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1948 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director Wm. Luden Sons

Address Bethesda, Maryland

19. Sept. 28, 1948 (Date rec'd by registror) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1948 to Sept 23 1948 and that I last saw ____ alive on Sept 23 1948

Immediate cause of death Coronary Occlusion — OURATION: 1 hour

Due to ____

Due to ____

Other conditions ____

(Include pregnancy within 3 months of death)

Major findings of operation ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Frank J. Broschart M.D. M. D. or other

Address Gaithersburg Md Date signed 9-23-48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The (or) age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09563

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1240 11th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME SMITH, James Franklin James F. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male XMITH	White	Married

6.(b) Name of husband or wife: Gertrude W Smith 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-27-95

8. AGE: Years	Months	Days	If less than one day
53	2	12	hrs. min.

9. Birthplace: Lancaster, Pennsylvania (Town, county, and state)
10. Usual occupation: Government Gaurd
11. Industry or business

FATHER 12. Name: Unknown
13. Birthplace

MOTHER 14. Maiden name: Unknown
15. Birthplace

16. Informant: Wife: Mrs. Gertrude W. Smith
Address: 1240 11th St., N. W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 13 September, 48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W.W. Chambers Funeral Home
Address: 1400 Chapin St NW Washington DC

19. 9-10 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 19 48 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Chronic subdural hematoma bilateral extensive	
Due to: Arteriosclerosis, Coronary	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other
Address: Gaithersburg Md. Date signed 9-10-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09564

472

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month, 6 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? one month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3042 Bista St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME

SPEORL, Charles Fred

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence O. Speorl

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 7, 1895

8. AGE: Years	Months	Days	If less than one day
53	7	2	....hrs. ....min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER
12. Name: SPEORL, Frank dec.
13. Birthplace: Pa.

MOTHER
14. Maiden name: KRAFT, Minnie
15. Birthplace: Pa.

16. Informant: wife: Mrs. Florence O. Speorl

Address: 3042 Bista St., N.E., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-21-48 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Washington, D.C.

18. Funeral director: W.W. Chambers H.E.O.

Address: 5801 Cleveland Ave, Riverdale, Md.

19. 9-19 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 September 19 48 at 3:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 August 19 48 to 19 Sept. 19 48 and that I last saw h... alive on 19 September 19 48

Immediate cause of death	DURATION
Terminal pneumonia	48 hrs.
Due to: Carcinoma, bronchogenic	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: S. R. Mills Jr. S. R. MILLS, Jr., Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-19-48

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

09565

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs.

Hospital, institution, or street address where death occurred:
Metropolitan Grove

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Rural Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Metropolitan Grove
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Stevenson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Infant.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1948 9 45 A.M.

8. AGE: Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace: Gaithersburg Md RFD 3
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name:
13. Birthplace

MOTHER
14. Maiden name: Dorothy B. Stevenson
15. Birthplace: Gaithersburg Md

16. Informant: Dorothy B. Stevenson
Address: Gaithersburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7 1948 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Mt Zion, Md.

18. Funeral director: Earl Lee Stevenson Grandfather

Address: Gaithersburg Md

19. Sept. 6 19 48 Albert L. Clarke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 19 48 at 12 45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 6 19 48 to Sept 6 19 48 and that I last saw h.. alive on Sept 6 19 48.

Immediate cause of death	DURATION
Premature	3 hrs.
Due to:	
Embarrassment	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm Sherley MD
M. D. or other

Address: Gaithersburg Date signed: Sept 6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09566

186a

Reg. Diat. No. 714

1. PLACE OF DEATH:
County MONTGOMERY
City or town SILVER SPRING MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ YEARS
Hospital, institution, or street address where death occurred:
1403 NOYES DRIVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1403 NOYES DRIVE
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME
ANNIE HILTON STRICKLAND

3.(b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	wh	WIDOW

6.(b) Name of husband or wife CLARENCE C. STRICKLAND
DECEASED 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 2 1876

8. AGE: Years	Months	Days	If less than one day
72	5	28	..... hrs. ..... min.

9. Birthplace CLARKSBURG MARYLAND
(Town, county, and state)
10. Usual occupation WIDOW
11. Industry or business none

FATHER
12. Name Geo. W. Hilton Deceased
13. Birthplace CLARKSBURG MD.

MOTHER
14. Maiden name FRANCIS SCOTT
15. Birthplace CLARKSBURG MD.

16. Informant Mrs E.C. Holmead
Address 1403 NOYES DRIVE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2, 1948 (month) (day) (year)
Cemetery or crematory Elkton Presbyterian Church
Location Elkton, Maryland
18. Funeral director Warner E. Pumphrey, Inc.
Address 8434 Ga. Ave. Silver Spring, Md.

19. Oct 1 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948, at 10.00 AM PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1948, to Sept 30 1948
and that I last saw h.. alive on Sept 30 1948

	DURATION
Immediate cause of death Pneumonia	4 days
Caused by continuous confinement in bed	4 MOS
Due to Fracture of hip	
June 9- 1948	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of June 9, 1948
Where did injury occur? Montgomery County (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury fell down cellar steps Injured at work? [10/22/48 phc]

23. SIGNATURE Richard B. Phillips M.D. or other
Address 8248 Georgia Ave Date signed 9-28-48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09567

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8½ days

Hospital, institution, or street address where death occurred: Suburban Hospital 8600 Old Georgetown Rd. - Bethesda Md.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3703 Jennifer St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Helen M. Sullivan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband ~~or wife~~ John Sullivan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1859

8. AGE: Years	Months	Days	If less than one day
88	11	25	..... hrs. ..... min.

9. Birthplace LINGLESTOWN, PA.

(Town, county, and state)

10. Usual occupation NONE

11. Industry or business —

FATHER 12. Name LEVI HOFFA

13. Birthplace UNKNOWN

MOTHER 14. Maiden name MARY WILSON

15. Birthplace UNKNOWN

16. Informant LEAH CORBIN

Address 3703 JENIFER St., N.W.

17. Burial (Burial, cremation, or removal. Write) Date thereof 9-17-48 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Lurtland Md

18. Funeral director Joseph Gawler's Sons, Inc.

Address 1756 Pa. Ave., N.W. Wash. 6, D.C.

19. 9/16 1948 Mrs E Johns Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 1.05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 Sept. 1948 to 15 Sept 1948 and that I last saw her alive on 14 Sept 1948

Immediate cause of death	DURATION
Bronchopneumonia, Bilateral, diffuse all lobes, type undetermined	12 days
Due to Secondary & chronic pulmonary edema	6 wks
Due to Myocardial decompensation	6 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of .....

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Stewart Aledd, M.D. M. D. or other

Address 3921 Ingomar St. Wash. DC Date signed 9.15.48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09568

47a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 24 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Beltsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am. & WWI veteran

3.(a) FULL NAME: TOLAND, Edward Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1876

8. AGE: Years: 72 | Months: 5 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER

12. Name: TOLAND, Joseph dec.

13. Birthplace: Pa.

MOTHER

14. Maiden name: HAANEY, Margaret dec.

15. Birthplace: Pa.

16. Informant: cousin: Mrs. Maggie Ellis

Address: 1048 S. 58th St., Phila., Pa.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 9-9-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 9-7 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 September 19 48, at 7:51 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 July 19 48 to 7 Sept. 19 48 and that I last saw him alive on 7 September 19 48

Immediate cause of death	DURATION
Hemorrhage	
Due to: Erosion left Common Carotid Artery	
Due to: Carcinoma larynx	
Other conditions: Metastatic Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations: Extrinsic carcinoma larynx, invading tongue. Date of op. 8-9-48

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. J. DELANEY, Capt. MC USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 9-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940a

Reg. Dist. No. 216

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5108 Custer Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Frank Turton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna E Turton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE:

Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace: D C

(Town, county, and state)

10. Usual occupation:

11. Industry or business: U S Govt

FATHER

12. Name: Edward Turton

13. Birthplace: D C

MOTHER

14. Maiden name: Annie V. Brown

15. Birthplace: D C

16. Informant: Mrs Edna E. Turton

Address 5108 Custer Rd. Bethesda Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cem.

Location: Prince Georges County Md

18. Funeral director: Cheney Chandler Funeral Home

Address 5103 Wisconsin Ave.

19. 9/15 (Date rec'd by registrar) 1948 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1948 at 940A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1941 to Sept 1948

and that I last saw him alive on Sept 13 1948

	DURATION
Immediate cause of death: Coronary Thrombosis	20 Minutes
Due to: Arteriosclerosis	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis Brown MD M. D. or other

Address 5016 Hampden Lane Date signed 9/15/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

15236A
09570
160c

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME CARL ROBERT TYNES ~~Baby Boy Jackson~~

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	new born

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1948

8. AGE: Years: 3 hrs- | Months | Days | If less than one day: 3 hrs. ..... min.

9. Birthplace: Bethesda - Mont. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: CARROLL ROBERT TYNES
13. Birthplace: MONT. Co., MD.

MOTHER
14. Maiden name: Ethel Jackson
15. Birthplace: Seneca, Md-

16. Informant: Ethel Jackson
Address: Seneca, md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9-14-48 (month) (day) (year)
Cemetery or crematory: Suburban Hospital
Location: 8600 old Georgetown RD Bethesda - Md

18. Funeral director: A. B. Salon
Address: Bethesda, md

19. Sept 18 1948 (Date received by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13, 1948, at 7 15 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 13 1948, to SEPT 13 1948 and that I last saw h IM alive on SEPT. 13 1948

Immediate cause of death	DURATION
ATELECTASIS	FROM BIRTH
Due to ANEMIA	
Due to PREMATURE SEPARATION OF MATERNAL PLACENTA	2-10 MINS
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE
Date of op.
Autopsy results: LARGE BABY, ATELECTASIS, ANEMIA

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Ira W. Pearlman M.D.
M. D. or other
Address: Suburban Hospital Bethesda 14, Md. Date signed 9-15-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

165 09571

Reg. Diat. No. 714

1. PLACE OF DEATH:
County unknown Found Mont
City or town unknown Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
unknown
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State unknown County unknown
City or town unknown Tak. Pk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. unknown
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby boy Unknown

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) unknown 9-1948

8. AGE: Years	Months	Days	If less than one day
full term			..... hrs. ..... min.

9. Birthplace unknown
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 1, 48 (month) (day) (year)
Cemetery or crematory County Home
Location Rockville, Md.

18. Funeral director Warren E. Pumphrey, Inc.
Address 8434 Ga. Ave. Silver Spring, Md.

19. Oct 1 (Date rec'd by registrar) 1948 Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH About Sept 30 1948, at ? [ ] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med Exam to Case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
unknown	
Due to Full term baby found dead	
Due to Sligo Creek Hotbird 7334 Piney Branch Rd, Takoma Park, Md	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Stillborn baby born alive

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frazl J. Bronchart M.D. Sept med Exam
M. D. or other
Address Gaithersburg md Date signed 9-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

09572

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rfd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Marjorie Walker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married.

6.(b) Name of husband or wife Mr. F. Carroll Walker

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 18, 1896 ~~1898~~

8. AGE: Years ~~51~~ 52 | Months 9 | Days 10 | If less than one day hrs. min.

9. Birthplace Gaithersburg, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Mr. Samuel Plummer

13. Birthplace Gaithersburg, Md.

MOTHER 14. Maiden name Miss Ellen Pope

15. Birthplace Montgomery Co. Md.

16. Informant Mr Carrol Walker

Address Gaithersburg Md

17. Burial Date thereof 9/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg Md

18. Funeral director Ernest C Gartrell

Address Gaithersburg Md

19. Sept. 30 1948 Alma W. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1948 at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Sept. 28 1948 and that I last saw her alive on September 28 1948

Immediate cause of death	DURATION
Acute ascending myelitis (Landry's)	6 days
Due to paralysis (Not Polio) (10,254 B)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. J. Bozhart M.D.
M. D. or other

Address Gaithersburg, Md. Date signed 9/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09573

77d

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war

3.(a) FULL NAME Clara Washington

3.(b) Social Security Number None

4. Sex Female | 5. Color or race Colored | 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband ~~or wife~~ George F. Washington

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11. 1874

8. AGE: Years 74 | Months | Days 25 | If less than one day ..hrs. ..min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Nathaniel Harris
13. Birthplace Va.

MOTHER 14. Maiden name Amelia Johnson
15. Birthplace Va.

16. Informant George F. Washington
Address Saratoga ave. Takoma Park

17. Burial (Burial, cremation, or removal) Which?) Date thereof Sept. 10. 1948 (month) (day) (year)
Cemetery or crematory Lincoln Park.
Location Rockville, md.

18. Funeral director Robert L. Burgoyne
Address Rockville, md.

19. Sept 10 1948 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept Med Exam care 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral edema	1 week
Due to Chronic alcoholism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brockhaus M. D.
M. D. or other
Address Gaithersburg md Date signed 9-9-48

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
SEP 14 1948
1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09574

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2504 11th St., N. E., Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: WEINER, Phillip (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Edith Reba Weiner

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 13, 1897

8. AGE: Years	Months	Days	If less than one day
51	2	28	..... hrs. ..... min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: Government Printing Office

11. Industry or business: Proof Reader

FATHER — 12. Name: WIENER, Max

13. Birthplace: Russia

MOTHER — 14. Maiden name: COOPERMAN, Rachael

15. Birthplace: Russia

16. Informant: WIFE: Mrs. Edith R. Weiner

Address: 2504 11th St., N. E., Wash., D.C.

17. burial Removal Date thereof Sept. 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Holly

Location: Phila., Pa.

18. Funeral director: Goldstein Funeral Home
~~W. W. Chambers~~

Address: 1400 Chapin St N.W Washington DC 2129 Brandt Phila. Pa.

19. 9-11 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 September 19 48 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Sept. 19 48 to 11 Sept. 19 48 and that I last saw him alive on 11 Sept. 19 48

Immediate cause of death	DURATION
Thrombosis, Coronary Artery	3 days
Due to: Arteriosclerosis, Generalized	undet.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: W. F. Queen
W. F. QUEEN, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-11-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09575

CERTIFICATE OF DEATH

Reg. Dist. No. 2 / 3

1. PLACE OF DEATH:
County MONTGOMERY
City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: CHESTNUT LODGE
How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County FREDERICK
City or town FREDERICK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 West Third St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME CHARLES WERTHEIMER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	WIDOWER

6.(b) Name of husband or wife ANNA MARY WERTHEIMER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JAN. 29, 1861

8. AGE: Years 87 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Tremont, Schuylkill Co., Pa.
(Town, county, and state)

10. Usual occupation CLOTHING MERCHANT

11. Industry or business STORE - RETIRED

FATHER
12. Name FREDERICK WERTHEIMER
13. Birthplace GERMANY

MOTHER
14. Maiden name CLOTHILDE KARLEY
15. Birthplace GERMANY

16. Informant SON - PHILIP WERTHEIMER
Address 122 No. COURT ST., FREDERICK

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-48 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick - Maryland

18. Funeral director C. E. Cline & Son
Address Frederick - Md.

19. 9/20 (Date rec'd by registrar) 19 48 E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept 1948, at 2:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
TOXEMIA	
Due to GANGRENE OF THE LEFT FOOT	
Due to MILD DIABETES & ARTERIOSCLEROSIS	3 5 yrs ?
Other conditions CEREBRAL ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Stanley N. Pollard, M.D.
M. D. or other
Address Rockville, Md. Date signed 9/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 d

09576

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo.
Hospital, institution, or street address where death occurred: 5606 Glenwood Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5606 Glenwood Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Alfred Scott Wilkins

3.(b) Social Security Number: 141 03 3737

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Effie S. Wilkens
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): 10-24-1908

8. AGE: Years	Months	Days	If less than one day
39	10	18	... hrs. ... min.

9. Birthplace: Norfolk Virginia (Town, county, and state)
10. Usual occupation: Real Estate-Own
11. Industry or business: Own Real Estate Business

FATHER
12. Name: Arthur S. Wilkens
13. Birthplace: Philadelphia, pennsylvania

MOTHER
14. Maiden name: Ida Arnold
15. Birthplace: Norfolk Virginia

16. Informant: John H. Wilkens Jr.
Address: Wilkens Office

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/15/48 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Washington, D.C.

18. Funeral director: Wm. Sherman Pumphrey
Address: 7557 Wisconsin Avenue

19. 9/15 1948 (Date rec'd by registrar) Wm E Jacobs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1948, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1948 to Sept 12 1948
and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage due to	
Secondary to Gun Shot Wound	✓
Due to: Trauma (Suicide)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 9-12-48
Where did injury occur? Bethesda (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: safety razor blade Injured at work?

23. SIGNATURE: Frank J. Bouchard M.D.
Dep. med. Exam. M. D. or other
Address: Gaithersburg Md Date signed 9-12-48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09577

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital, Old Georgetown Rd.
How long in hospital or Institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montg.
City or town: Poolesville, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE D. WILLARD

3.(b) Social Security Number: 216-22-2480

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary M Willard
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): July 20 - 1868

8. AGE: Years: 80 Months: 1 Days: 20 If less than one day: hrs. min.

9. Birthplace: Buckeystown, Md (Town, county, and state)
10. Usual occupation: Retired Tank employee
11. Industry or business

FATHER
12. Name: DeWalt Willard
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Sarah Etta
15. Birthplace: Maryland.

16. Informant: Ernest Willard
Address: Poolesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 22-48 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville, Md.

18. Funeral director: William B. Hilton
Address: Barnesville, Md

19. Sept. 21 1948 (Date rec'd by registrar) W. E. Jones (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18 1948 to Sept. 19 1948
and that I last saw h... alive on Sept. 19 1948

Immediate cause of death	DURATION
Uremic poisoning	3 days
Due to: Generalized mixed spread carcinoma	6 months
Due to: carcinoma of the prostate gland.	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none
Date of op.
Autopsy results: Generalized metastatic carcinoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John S. Fennell M.D. M. D. or other
Address: P. O. Boyds, Md Date signed: 21 Sept 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a 09578

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ Days
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 3½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10 Thomas Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Dr. BARRETT P. WILLSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anne O. Willson
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): June 30th, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	27	— hrs. — min.

9. Birthplace: Rockville, Montg. Co., Md. (Town, county, and state)
10. Usual occupation: Dentist
11. Industry or business: Own office

FATHER
12. Name: John E. Willson
13. Birthplace: Rockville, Maryland

MOTHER
14. Maiden name: Ella Gilpin
15. Birthplace: Rockville, Maryland

16. Informant: Anne O. Willson (wife)
Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/29/48 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm. Rawlings Sumpter
Address: Rockville, Maryland

19. Sept. 29, 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1948 at 1230 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 15 1948 to Sept 27 1948 and that I last saw h... alive on Sept 26 1948

Immediate cause of death	DURATION
(a) Myocardial insufficiency	2-3 yrs
Due to: (b) Arteriosclerosis	
Benign grade III	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Benign hyperplasia prostate Date of op. 9/24/48
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wallace Sterling M. D. or other
Address: 204 R St. NE Date signed: 9/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09579

52a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County. MONTGOMERY
City or town 15 EAST LENOX ST., CHEVY CHASE, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town CHEVY CHASE, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 E. LENOX ST. CHEVY CHASE, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME FRANCIS WINSLOW

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of [redacted] wife LAURA BRYN
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) JUNE 21, 1889

8. AGE: Years	Months	Days	If less than one day
59	3	5	..... hrs. ..... min.

9. Birthplace JAMESTOWN, R. I.
(Town, county, and state)
10. Usual occupation REAL ESTATE
11. Industry or business

MOTHER FATHER
12. Name FRANCIS WINSLOW
13. Birthplace LEGHORN, ITALY
14. Maiden name HARRIET PATTERSON
15. Birthplace SAN FRANCISCO, CALIFORNIA

16. Informant PEARSON WINSLOW
Address 575 PARK AVE., NEW YORK CITY N.Y.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1948 (month) (day) (year)
Cemetery or crematory OAK HILL CEMETERY
Location WASHINGTON, D.C.
18. Funeral director Joseph Gawler's Sons
Address 1756 Penna. Ave. N.W.
19. 9/27 19 48 W. E. Jones, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 19 48 at 11 55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 1, 19 48 to Sept. 26 19 48
and that I last saw h[redacted] alive on Sept. 25 19 48

Immediate cause of death	DURATION
Cancer R.L. Kidney - metastases	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. C. Hoffman M. D. or other
Address 1912 R St. N.W. Date signed 9-26-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09580

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11½ yrs.

Hospital, institution, or street address where death occurred:
Washington San. & Hosp., Takoma Pk

How long in hospital or institution? 11½ years (4205 Days) Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 629 Quebec Place, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Mr. Adolph William Wurdeman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1864

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	6	21		

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Model Makers

FATHER

12. Name: Herman Wurdeman

13. Birthplace: Oldenburg, Germany

MOTHER

14. Maiden name: Mary Bailauf

15. Birthplace: Baltimore, Maryland

16. Informant: Family Records

Address: Tk. Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28, 1948 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington, D.C.

18. Funeral director: Frank Stein Sons Company

Address: Washington D.C.

19. SEP 25 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1948 at 1:49 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948, to Sept 24 1948, and that I last saw him alive on Sept. 24 1948

	DURATION
Immediate cause of death: Terminal Pneumonia	3 days
Due to: Left Cerebral embolism	5 days
Due to: Arteriosclerotic heart disease with Auricular fibrillation	1 week
Other conditions: Parkinsonism	years

(Include pregnancy within 3 months of death)

Major findings at operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Name of injury: Injured at work?

23. SIGNATURE: DeForest Meade M.D. M. D. or other

Address: Takoma Park, Md. Date signed 9-25-48

3605 14th St, NW